Senate Select Committee on

MEDICAID REFORM

Lisa Carlton, Chair
Jeffrey Atwater, Vice Chair

This packet contains written comments from the public received during the Medicaid Reform meeting held in ***Jacksonville*** on March 14, 2005.

All comments submitted have been included in their entirety for consideration by members of the Senate Select Committee on Medicaid Reform and the House Select Committee on Medicaid Reform.

Florida College of Emergency Physicians

A CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
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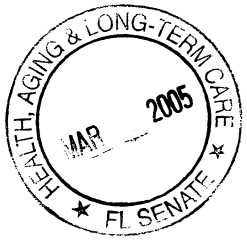
March 4, 2005



Dr. Michael Garner, Staff Director
Senate Medicaid Reform Committee
530 Knott Building; 404 South Monroe Street
Tallahassee, FL 32399-1300

Dear Dr. Garner:

On behalf of the Board of Directors of the Florida College of Emergency Physicians, please accept our sincere thanks and appreciation for working with Governor Bush on Medicaid reform. We are grateful for your willingness to explore options to reform our Medicaid system. It will take a great deal of political courage to ensure our Medicaid system is both solvent and remains accessible to those most at risk. As emergency physicians, our members represent the *de facto* source of primary care for most Medicaid subscribers. The emergency department is the only reliable source of health care available 24 hours a day, 7 days a week.

The Florida College of Emergency Physicians would like to take this opportunity to share our thoughts on issues related to Medicaid reform specific to emergency medicine. We are pleased to support any reform proposals which ensure continued universal access to emergency and trauma care for everyone, and keep our emergency care safety net intact. Here are some important points to remember:

Principles

- Florida must continue to ensure the continued availability of quality emergency and trauma care for all patients.
- All patients who need medical care should be provided timely care in an appropriate setting based on the individual patient's needs.
- Decreasing payments to providers of emergency care will not decrease inappropriate utilization of hospital emergency departments.
- Emergency and trauma care must be given special consideration in determining a payment mechanism for the provision of care to Medicaid patients.

We agree that based on current projections, the Medicaid program in Florida may soon become unsustainable in its current form. Unless changes are made, the state will have to face continued pressure to decrease costs. Maintaining high quality care will be next to impossible under those conditions. Yet reform will take more than just spending money in different ways. It will require a change in the behavior of everyone. Consumer driven models encourage more personal responsibility by rewarding healthy lifestyles. It is also incumbent upon the State to begin to provide education and information resources so consumers can be properly educated on personal health care maintenance. Through personal responsibility and education, we can begin to lower long-term health care costs.

It is important to remember, however, that emergency and trauma care are *fundamentally different* components of our health care system. They are designed to address unique health care crises that come without warning or are unexpectedly necessary. Emergency physicians are trained to stabilize patients presenting with numerous symptoms and injuries, diagnose their needs and obtain the appropriate follow up care when necessary. Typically, there is no formal doctor-patient relationship in the traditional sense. Patients come to the emergency department and may not have detailed knowledge of their medical history or may be unable to respond to questions. Emergency physicians have to make life-and-death decisions quickly, based on limited knowledge of the patient. Federal and state laws rightly require hospital emergency departments and emergency physicians to treat all patients, regardless of their ability to pay or their participation in government assistance programs such as Medicaid. Other health care providers may choose not to participate in programs like Medicare or Medicaid. Consumers with a health care emergency do not have the ability to "comparison shop" for the best prices because they have an emergency, and they rightly expect high quality care. Emergency care providers do not have the ability to determine which patients they want to see; they, therefore, provide high quality care to everyone. There are different market forces at work in the hospital emergency department setting compared to the rest of the traditional health care system.

Emergency Care Issues in Medicaid Reform

Below is an outline of specific issues to emergency and trauma care in Medicaid reform.

Special Consideration for Emergency Care Providers

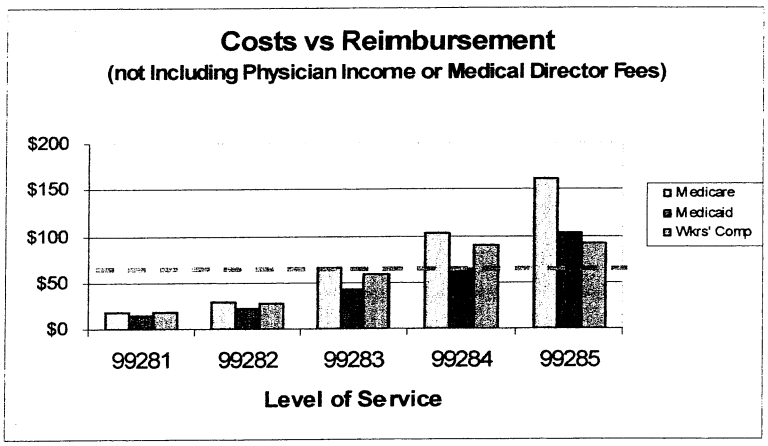
Medicaid reform must protect the only universally available source of health care – the emergency care safety net. Federal and state laws mandate that care be provided regardless of a patient's ability to pay. The state must protect access to emergency care by ensuring an adequate reimbursement mechanism for the provision of emergency and trauma care that is separate from any market-based structure.

Prescription Issues

The growing cost of pharmaceutical drugs subtracts from the available resources that pay for physician services. As physician reimbursement declines, access to care is also adversely impacted. Also, the lack of control over prescriptions affects emergency physician practice and the Medicaid budget. There are inadequate controls over duplicate prescriptions and the utilization of benefits by others inappropriately.

Diverting Non-Urgent Medicaid Patients from the Emergency Department

Non-urgent Medicaid patients – those normally reimbursed at levels 1-2 (99281-99282); and urgent cases treatable in an out-patient setting (many 99283's) – cause emergency physicians to actually lose money. There is no incentive for emergency practitioners to see non-urgent cases. These patients are typically "churned" through the system without a definitive follow-up plan, as they lack access to specifically scheduled follow-up appointments and care. This increases short-term and long-term Medicaid costs, as the lack of follow-up from providers means patients continue to return to the emergency department with chronic health care problems. The chart below illustrates an example in Miami-Dade County in 2004 of the cost to emergency physicians to provide care to Medicare, Medicaid and Workers' Compensation patients vs. the compensation received from Medicaid for each level of service. (The red dotted line represents the fixed costs to cover only malpractice and billing costs to the emergency physician to provide services and does not include other costs or any compensation to the physicians.) The physicians are not seeing the patients for free, they are losing money in all but the highest acuity Medicaid patients.



Delivery of Integrated Care

It is critical – both to the Medicaid program and the emergency physician – for emergency care to be provided in the most cost-effective manner. It goes without saying that quality care is the most cost-effective care, because this reduces long-term costs to the overall health care system. Emergency physicians must be integrated into the overall health care delivery system to Medicaid subscribers. The first step should be to provide emergency physicians immediate access to electronic patient records. It is also important to ensure that appropriate, full-time 24-hour accessible case management services are provided to Medicaid subscribers so that emergency physicians can ensure that appropriate follow-up care is available.

Continuity of Care

The inability of emergency physicians to arrange for appropriate follow-up care has adverse consequences for the emergency physician, the Medicaid program and most importantly, the patient. Unless emergency physicians can guarantee timely follow-up care, they will be forced to admit Medicaid patients to the hospital, driving up costs substantially. This lack of follow-up care results in the emergency department being utilized as the primary source of care, which is both inefficient and inappropriate. Concurrent with this point, an appointment at a public clinic two or three months down the road is <u>not</u> follow-up care. So it is important that the Medicaid program ensure that case-management services are available in a timely manner – i.e., within the medically suggested time-frame.

Emergency care is not "Free Care"

Federal and state laws mandate that emergency departments and emergency physicians provide care to all patients who come to the emergency department, regardless of their ability to pay. We support this requirement to ensure everyone has universal access to emergency and trauma care. However, many individuals choose not to acquire health insurance, knowing that this care is available to them regardless of their ability to pay or the cost to the providers to provide care. Often, they will quote their rights on arrival to the emergency department. (Laws also mandate that these rights also be posted.)

According to a recent study by the American Medical Association, the typical emergency physician accumulates more than $130,000 each year in "bad debt" providing care as a result of requirements to do so. Because Florida has a higher uninsured population, this number is likely greater for emergency physicians here. However, just using the national figure, we can estimate that the approximately 1,700 emergency physicians practicing in Florida provide $221 million in uncompensated care each year.

As long as there is a mandate to provide emergency and trauma care, emergency physicians will always bear a substantial cost providing uncompensated care. We understand that is just the nature of our specialty. However, policy makers must take this in to consideration when reforming our health care system and ensure that physician compensation levels are adequate enough. Further erosion of reimbursement for Medicaid providers of emergency care will only threaten access to care. Market forces will drive emergency physicians out of Florida and to states where reimbursement is higher.

Important Questions for Policy Makers

Here are some important questions that, as policy makers considering Medicaid reform, we believe you should consider:

1. How do we ensure that all patients have universal access to emergency and trauma care?
2. How do we guarantee payment under a new Medicaid system for emergency and trauma care?
    a. We cannot "capitate" emergency services since utilization cannot be denied.
    b. Current fees have already been shown to be inadequate. Further reductions will reduce access to emergency and trauma care.
3. How do we guarantee specialists such as orthopedists, neurosurgeons, obstetricians, plastic surgeons and dermatologists, will be willing and able to provide care to Medicaid patients in the emergency department?
4. How do we ensure that appropriate follow-up care is available and delivered?

Recommendations

We are pleased to provide you with recommendations which we believe will provide better care at a reduced long-term cost to the Medicaid program.

Special Consideration for Emergency and Trauma Care Providers

As stated above, federal and state laws mandate that emergency and trauma care be provided regardless of a patient's ability to pay for that care. This is an important state public policy. Medicaid reforms should take these mandates into account when crafting a new system of providing care, and ensure that emergency and trauma care providers are not adversely impacted.

Alternate Sites of Service

By providing alternate sites of care available during expanded hours – especially late nights and weekends – the Medicaid program will save money on inappropriate emergency department utilization as well as offering primary care for basic health care needs. The state can provide incentives to providers to operate alternate care sites. Having health care maintenance and prevention available to Medicaid recipients will also reduce long-term costs by reducing a patient's need to go to the emergency room to treat a chronic condition which has worsened.

Education, Communication and Case Management

One of the easiest ways the state can reduce costs and improve patient health is to provide educational resources and training on basic health maintenance. This can be done through schools as well as primary care providers participating in the Medicaid program. Education on proper diet, exercise and health maintenance will give consumers the power to make informed choices on their personal and family care.

The second critical step is for providers and patients to have immediate and free access to their health care records. This will reduce the need for practitioners to order duplicate diagnostic testing, treatment and prescriptions as well as discourage fraud.

Third, case managers and/or call centers should be available for emergency physicians to order appropriate and timely follow-up care 24 hours a day. The Medicaid program must also ensure that primary care and specialist care is accountable and available to assist in managing episodic care.

Address Pharmaceutical Costs and Nursing Homes

While physician reimbursement represents only 6% of the Medicaid program budget ($691 million), pharmaceutical costs account for 19% ($2.68 billion) and nursing home care accounts for 16% ($2.26 billion). We should require better identification of recipients and promote more efficient utilization through electronic prescription ordering (ideally part of an overall system of electronic patient records). Medicaid reform should also include pharmaceutical case managers as part of the overall case management system. Physicians cannot be expected to review pharmacy lists without immediate access to prescription records. Finally, the cost of nursing home care must also be addressed. In many cases, home based care is less costly and preferable for the patient.

Liability Reform

We understand that the Legislature has taken steps to begin to address Florida's medical liability system. One step that should be considered is to provide immunity to all providers of health care services to Medicaid patients if they agree to accept Medicaid rates. Reducing provider liability will reduce overhead costs to the provider, making Medicaid rates more attractive without having to increase Medicaid rates. This is especially important to specialists critical to our emergency and trauma care system, who are currently reluctant to see Medicaid patients in the emergency department, knowing that reimbursement is so inadequate while they stand a good chance of being sued.

Funding

Ultimately, the resources provided will determine the availability and quality of care. Any new reimbursement system must include a mechanism to ensure that emergency and trauma care is provided with appropriate compensation. Fixed costs of providing emergency care must be realized when determining appropriate reimbursement. If the current Medicaid fee schedule is to be eliminated, then at a minimum, the Medicare fee scheduled should be approved for use for emergency physicians and consultant services. An alternative may be fee schedules developed with a specific carve out for episodic care, at adequate reimbursement rates adjusted yearly for the increased costs of providing care, such as escalating malpractice premiums.

Again, we appreciate the political courage you and Governor Bush are showing in addressing Medicaid reform. This is a monumental task and vitally important to those most vulnerable. We stand willing to work with you to construct a system which protects access to emergency care, improves the quality of care while addressing the long-term costs to the Medicaid program.

If you have any questions or would like to speak further on any of the points raised, please do not hesitate to contact me or Jake Bebber, Deputy Executive Director, at (407) 281-7396 x20 or via email at jbebber@fcep.org.

Sincerely,

Arthur L. Diskin, MD FACEP
President

Cc: The Hon. Jeb Bush, Governor
The Hon. Tom Lee, President of the Florida Senate
The Hon. Alan Bense, Speaker of the Florida House
Alan Levine, Secretary, Agency for Health Care Administration

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My name is Connie Carter. I live in Davenport, Fl. with my husband and 2 sons, Tim, age 24 and TJ, age 13. Both boys were born with disabilities: Tim has Bipolar D.O. and Tj has multiple physical and developmental challenges. My father, age 78, is in long term care with multiple health issues. Because of this, they are all in dire need of adequate health care. Both my father and youngest son are Medicaid participants. My son with Bipolar D.O. has no coverage as he is currently working and cannot receive Medicaid benefits under its current guidelines.

My son, TJ, however, receives the most comprehensive coverage. Medicaid has even provided a special lift for him that is not usually covered because he requires a special bed for health and safety issues and the customary lift does not fit in it. By making special considerations for this lift, TJ should be able to be maintained in his home environment through adulthood as long as his other needs continue to be met. Though there are definite concerns to be raised for both the elderly and the mentally ill as well, my focus today will be on children with special health care needs who are served by the Medicaid program.

When considering Medicaid reform, my biggest concern for TJ would be a "Cap" put on coverage and/or benefit limitations. Children like TJ often require undeterminable amounts of such interventions as medical care, home health care, and durable medical equipment, just to sustain life: something that many of us take for granted. Most of us need very little help eating and breathing. Not so for our most medically fragile children. A Cap on benefits or services rendered would be a health and safety risk for my son. It would make it virtually impossible to care for him long term at home due to his increase in needs as his body continues to grow from childhood to adulthood, if he survives the changes. That's not to say that changes aren't necessary. They are. I would like to offer some suggestions that might allow the Medicaid system to use funds more efficiently.

They could include but not be limited to:

1) Home Health care services such as Private Duty Nurses, being paid at a higher, standardized percentage of the Medicaid reimbursement while their respective agencies would function within the constraints of the remainder of the reimbursement. This would provide a better rate of pay for the direct care providers while maintaining that funding would be used appropriately: for care of the patient not for variable agency expenditures. . It's not that we want to put agencies out of business, just limit their expenditures to the necessary care of the child and it's related overhead , not for bigger more lavish office space.
2) One better would be to expand the CDC+ program offered through the Med Waiver to include all consumers that are Med waiver "eligible", eliminating the agency overhead.
3) Families could be required to use a monthly ordering system instead of being offered automatic delivery when using DME companies for durable Medical Equipment and medical supplies. Currently, many companies ship out a standard order to families monthly whether we need supplies or not. Personally, I consider that to be a colossal waste of Medicaid dollars. By requiring that families or direct care providers order only what they need on a monthly basis, Medicaid uses their dollars more wisely by eliminating the waste while still providing what our children need. By saving money, Medicaid, in turn, could provide other needed supplies or services not offered through the current system.

4) Those individuals in need of durable medical equipment and related supplies, would continue to require letters of Medical Necessity while a standardized percentage of the Medicaid reimbursement on equipment would, once again, assure that Medicaid dollars are spent more efficiently and wisely: for the actual care of our sick and disabled loved ones not for larger, more profitable agencies.

To summarize, there may be ways to spend Medicaid dollars more efficiently without capping or restricting benefits for our children with special medical needs. I am concerned that, without some needed changes, the Medicaid system will fail to serve its most vulnerable population. These are the very same individuals that it was originally designed to serve.

In conclusion, I would like to thank you for this opportunity to have input into the Medicaid reform proposal. By doing this you have allowed us to share our concerns and possibly offer viable options to making the Medicaid program work more efficiently, while providing a better system of care to those who need it most....our precious children.

Thank you again for your time in this matter.

Sincerely,

Connie Carter

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The attached was requested from a member of the Academy of Florida Elder Law Attorneys. If you need more information, please contact me.

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MEDICAID LONG TERM CARE

Recommendations to the Senate Select Committee on Medicaid Reform

Academy of Florida Elder Law Attorneys

February, 2005

Introduction and Background.

How is the Medicaid program involved in providing nursing home and other long term care? Unless one has had a family member who found themselves in need of nursing home care, most Floridians would not realize the dilemma our elderly face. Thinking they have the costs of their medical needs covered through Medicare and their private Medigap policy, they realize too late that certain medical needs are simply not covered. In essence, Medicare is a terrific program for what it covers. Most senior citizens would pay nothing for a hospital stay or surgical procedure. Unfortunately there are two types of medical needs that are simply not covered by Medicare. Much publicity has been given to the fact that Medicare (until recent legislation) has not covered prescription medications. Fortunately, that problem has been recognized and relief will be provided. The other is the need for nursing home care or equivalent care in the home or an assisted living facility. The only program that provides assistance to the elderly in meeting long term care needs is the Medicaid program. Through the Medicaid program, senior citizens whose health requires this care are forced into poverty and sometimes treated as if they are second class citizens.

The following are certain underlying facts that are important to understand in order to appreciate the desperate financial crisis faced by many of our elders.

1. Who are we talking about? The elderly with any of the following chronic medical conditions can find themselves in need of unavailable and unaffordable care:

Alzheimer□s disease and other forms of dementia,
Parkinson□s disease,
Post-stroke syndrome,
Diabetes,
Lou Gehrig□s Disease (ALS),
Multiple Sclerosis,
Neurological disorders,
Emphysema
Debilitating rheumatoid arthritis,
COPD.

2. Senior citizens with chronic illness are unfairly disadvantaged because the costs of their health care are not covered by Medicare. American public policy relating to chronically ill

elders is fundamentally flawed and coverage must eventually be merged into the Medicare system or provided in a similarly structured system.

3. Medicare was introduced with the promise that □the elderly would no longer worry about losing their life savings because of an illness.□ The reality of □millionaires on Medicare□ is accepted without question for those suffering acute illnesses, while the myth that there are many □millionaires on Medicaid□ has been used as a false justification for some of the recent draconian reform efforts. In the meantime the elderly middle class with the □wrong illness□ are forced into the Medicaid program due to the crippling costs of their illnesses.

4. The assignment of the long term care benefit to Medicaid in 1965 was never intended to create a disparity between the health care coverage of acute and chronic illnesses for the aged and disabled. Those involved in the creation of Medicare and Medicaid have acknowledged that they neither foresaw nor considered the increase in life expectancy resulting from new medical technology which prolongs life, and the resulting surge in the number and lifespan of chronically ill seniors.

5. The costs of long term care - regardless of the setting- can be just as financially devastating for the chronically ill as a hospitalization or operation for the acutely ill. The difference in the way the health care system treats them, however, is dramatic. For example:

Medical care	Approximate Costs	Payer
Heart surgery, hospitalization	approx. $150,000	Medicare and Medigap insurance
2 years of long term care	approx. $132,000	Private pay or be eligible for Medicaid

And unlike Medicare recipients who pay relatively small deductibles or co-payments, under the Medicaid Institutional Care Program (ICP) nursing home residents use their entire monthly income, less $35 allowed for □personal needs□, as their share of the cost of care each month. Even with spousal income allowances, the at-home spouse is then often left without sufficient income to maintain their existing standard of living.

6. The overwhelming majority of seniors needing long term care have savings of between $30,000 and $200,000. Many are children of the Great Depression and are World War II veterans. They are the very people Tom Brokaw has called America□s □Greatest Generation.□ They try to be responsible for their needs by securing a Medi-gap policy, not realizing that certain medical expenses are simply not covered.

7. Having the desire to pass an inheritance to one□s children or grandchildren is not something to be ashamed of. Passing inheritances to future generations is a fundamental precept of American society. Our federal government has enhanced that protection for the wealthy by moving to eliminate the estate tax. While recognizing the burden that health care costs in general place upon state and federal budgets, it must also be recognized that the middle class is left the most vulnerable to these costs. The indigent can receive assistance in paying for their care and the wealthy can rely upon personal wealth and expensive long term care insurance coverage. As a result, the middle class is unfairly impacted by the need to pay for ruinously expensive but essential medical care, and their

dreams of passing their hard earned savings to their children are dashed. Instead of deriding those in the middle class who share the desire to pass an inheritance to their children, the burden of health care costs for those over 65 should be fairly apportioned among all, regardless of the nature of their illnesses.

8. The primary needs of chronically ill seniors are medication management, behavioral redirection, nutritional oversight, nursing supervision, assistance with activities of daily living and safety. There is a common misconception which rises to the level of prejudice that these needs do not constitute medical care and therefore should be provided by family members at no cost to the health care system.

9. The majority of care for the elderly takes place in their homes or the homes of their children. Care givers place their spouse or parent in a nursing home as a last resort, only when sufficient care cannot be provided at home. Previously healthy care givers, in particular spouses, frequently develop life-threatening and chronic illnesses of their own resulting in a premature death or their need for acute and long term care, increasing their own health care costs. Studies show that there is a 60% stronger likelihood that the care giver spouse will end up needing care as a result of exhausting care giving responsibilities or will predecease the chronically ill spouse from stress and mental and physical exhaustion. But even when there are family care givers present, care in the home is not always enough and placement may be necessary to meet the elders needs.

10. In order to delay the onset of nursing home placement, adult day care should be made more widely available and affordable transportation opportunities for such care should be expanded. In addition the legislature should seek and support existing and new efforts to provide financial, physical and emotional support for family care givers because such measures permit longer care giving in the home and prevent the onset of health problems for the care giver.

Other ways to save money

A. Provide financial rewards for employees. As outsiders to the system, we see some changes that would result in cost savings. People inside the system (particularly in the Agency for Health Care Administration) must surely see others. We recommend that the state provide financial rewards for employees and others who are able to identify fraud or other wasteful administrative glitches that will result in savings to the Medicaid program.

B. Adequately fund the home and community based services program. In the long term care area, probably the biggest savings would come from the State of Florida adequately funding the Medicaid home and community based services programs, including the nursing home diversion program and the assisted living facility waiver program. We all know of clients who desire to keep their family member home rather than placing them in a nursing home. It can be one spouse caring for another or a child caring for one or both parents. The ability to continue to keep the family member at home may be dependent on assistance. Clients who have been fortunate enough to receive Medicaid home based services through the nursing home diversion program are pleased that they can provide this type of care at home. And the state saves a lot of money! This is capitated

managed care program costs the state approximately $2,000 per month, per recipient (including prescription medications.) It□s much cheaper to provide homemaking services and personal services to an individual in their home than pay for nursing home care. Nursing homes are the most expensive location to receive long term care. Note, the statewide average Medicaid nursing home reimbursement rate is $149.63 per day as of July, 2003. Prescription medications are additional. Due to inadequate funding, waiting lists for this program began in December 2004.

Likewise, the Assisted Living Waiver (ALE) program, provides care to these same individuals in a less restrictive and much less expensive environment. The monthly charge in an assisted living facility that participates in the Medicaid program is less than half of the charge for a nursing home. In fact many clients pay the majority of these costs out of their own income. This program has not had any significant funding for at least two years.

The Medicaid nursing home program is an entitlement program. The above described home and community based services programs are not an entitlement, but instead are based upon adequate funding levels. These programs require the same level of care for the recipient -so it□s not a matter of opening up the program to people who aren□t otherwise eligible for nursing home care - it□s just a matter of providing services in a less expensive manner.

C. Encourage Medicaid recipients to keep supplemental insurance. Most elderly clients have Medicare and a private Medicare supplement policy. When the client goes into a nursing home on ICP, rather than encourage the Medicaid recipient to retain their supplemental insurance, the State has until recently refused to allow the Medicaid recipients to deduct the cost of their Medicare supplement in determining patient responsibility. Department of Children and Family Services (DCFS) employees and nursing home employees have routinely advised applicants to immediately drop their private insurance. These residents are people who have serious health issues and are at the time in their life when they are most likely to benefit from these health insurance policies. The insurance company would certainly not insure them if coverage is dropped. Florida could be shifting the entire risk of their non-nursing home care to these insurance companies; instead, the State takes on all of the risk and financial responsibility.

While the state has recently changed its position and now permits the retention of the supplemental insurance, the state should aggressively promote the practice of educating and encouraging everyone to keep their insurance. In fact, as the governor□s proposal includes the component of funding private insurance, it should be something that the Agency for Healthcare Administration (ACHA) would follow through on, even for Medicaid recipients who are not inclined to do so themselves.

D. Screen for other coverage. ACHA should do a better job screening Medicaid recipients to ensure that Medicaid is in fact the payor of last resort.

1. For example, if a Medicaid ICP resident has private prescription coverage with a modest co-pay, there is no reason to believe that ACHA ensures that the pharmacy has billed the private insurer first. Instead, if the individual is Medicaid eligible, it is all billed to Medicaid. The number of elderly with prescription medication benefits has increased recently with the implementation of the Tri-care for Life program for military retirees. It provides for very modest co-payments. For a

nursing home resident eligible for Medicaid who has Tri-care coverage, this cost should not be borne by the State. This will also be an issue with the new Medicare prescription drug benefit. How will the State see that it is implemented correctly for dual eligibles?

2. Likewise, if a Medicaid ICP resident has a Medicare supplement (in addition to Medicare) and goes into the hospital or otherwise receives medical services which would be covered by the supplement, in what manner does ACHA ensure that the supplement pays prior to Medicaid?

E. Address Medicare denials in Nursing Home Care. Many residents of nursing homes begin their stay with Medicare coverage following a hospitalization. It is a common practice for a nursing home to prematurely determine that someone is no longer eligible for Medicare benefits. If there is no incentive for this determination to be appealed, the resident often begins receiving Medicaid benefits. An effort by the State of Florida to educate nursing homes regarding the standards to apply would result in the continuation of Medicare benefits for significant periods of time at substantial savings.

F. Ensure that recipients apply for other benefits. The Medicaid program is available to individuals who are under age 65 if they are disabled. All such individuals should be required to apply for Social Security Disability benefits. The result will be that after two years of disability, the individual will be eligible for Medicare coverage which will shift some of the cost of their medical expenses to the federal Medicare program (which is 100% federal funds) rather than having the costs come under the Medicaid program.

G. Improve the Medicaid Fraud Program. The State of Florida needs to do a better job safeguarding the state□s funds by aggressively investigating Medicaid fraud. It has been reported that Florida□s Medicaid program currently loses $1.4 billion per year due to fraud. Recent investigative reports in the Orlando Sentinel have shed light on the massive fraud that has occurred in Florida in connection with Medicaid funding a black market of painkillers and other controlled substances. Prescription fraud is just one of the rackets that illegally misappropriate state funds without adequate oversight by the agency charged with that task. The Orlando Sentinel (December 8, 2004) reported another story of Medicaid fraud involving prescription medications and indicated that the state has been unwilling to invest in a computer tracking system that would prevent this. Another recent Orlando Sentinel story dated February 11, 2005 reported that the move to privatize the Medicaid program will fuel even more undetected fraud according to the Office of Program Policy Analysis and Government Accountability, the auditing arm of the Legislature that review state programs for effectiveness and efficiency.

H. Reduce Administrative Costs. Various state and federal programs have different fiscal years that serve no valid purpose and result in substantial additional administrative costs. For example, for a married person receiving ICP Medicaid benefits there can be a diversion of income to the community spouse. For all ICP clients, annual cost of living adjustments (COLAs) that occur every January 1 results in changes to their finances that must be updated by the Medicaid case workers each January. But there is another change every July 1st that results in the need to again update the case and recalculate patient responsibility - the Medicaid Monthly Minimum Income Allowance (MMMIA). The income allowance available to a community spouse changes each July 1. This

results in significant duplication of work by the caseworkers that could be eliminated by simply changing the date of the MMMIA adjustment to January 1.

I. Eliminate the Income Limit. Florida has an arbitrary income limit for the ICP and HCBS programs. It is completely arbitrary in that it has no relation to whether the individual□s income is sufficient to pay for their care. For clients whose income exceeds the limit, there is a means to solve this problem - a qualified income trust (QIT). Unfortunately, people who are otherwise eligible for Medicaid have to see an attorney to create such a trust. In addition, the taxpayers have to pay for an attorney for DCFS to review each such trust to determine if it complies with the rules. The income limit and the qualified income trust serve no valid purpose for people in need of these services or the state. The only benefits accrue to attorneys and financial institutions.

J. Allow mental health crisis care to be provided in a non-hospital setting. Medicaid rules currently require people in need of emergency mental health care to receive that care in the most expensive setting - a hospital - rather than a state-licensed crisis stabilization facility that would charge less than 1/4 the cost. (See attached Orlando Sentinel editorial.)

K. Collect patient responsibility payments for the nursing home diversion program. Recipients on the nursing home diversion program who are receiving care in their home may or may not owe a patient responsibility payment depending upon their monthly income. If so, it is to be collected by the managed care provider. In such event, it is to be remitted to the state of Florida since the managed care provider is to receive a capitated rate and not receive a windfall because any particular Medicaid recipient owes a patient responsibility payment. It has been reported that there has simply been NO SYSTEM in place to have those amounts collected and paid to the State!!

L. Provide incentives for the purchase of long term care insurance. Four states have had pilot programs to encourage the purchase of long term care insurance by their residents. The basics of these programs have been that residents who purchase LTC policies that meet certain criteria can become eligible for Medicaid assistance when their LTC policies are exhausted without spending down all of their assets. Such a program would be a strong motivator for the purchase of LTC insurance because residents could know that they would be covered even if they outlived the period of insurance. Otherwise a potential purchaser of LTC insurance has no assurance that a 3 year policy would actually cover their needs if they live beyond the term of the policy.

M. Provide incentives to pay privately. As previously stated, our chronically ill elderly must deal with a system that is fundamentally unfair. They are not looking for a □freebie.□ When given a chance, they are willing to pay a fair share. This can be demonstrated with the number of elderly (65 and older) who have either a Medicare supplement (Medigap policy) or Medicare HMO. It is rare to meet a senior citizen who has not arranged for this coverage. Unfortunately, our health care system does not offer a fair alternative for those who need long term care. An example of this would be to modify the above described incentive to obtain LTC insurance to instead provide that nursing home residents who pay privately for a stated period of time (for example 2.5 years) could be eligible for Medicaid without spending down all of their assets. For many clients they would feel they could cover a given period of time - they worry about needing 5 - 10 years of nursing home care. This would be a win-win. Many such individuals who might have otherwise impoverished themselves in

order to become Medicaid eligible would end up never accessing the Medicaid program because they would pass away within the time frame of private pay.

N. Enforce the Elective Share Rights of a Surviving Spouse. Since 2001, Florida law provides that a surviving spouse is entitled to certain inheritance rights upon the death of a spouse under FL Stat. 732.201. (Note, it is generally 30% of the deceased spouse□s assets.) If the surviving spouse is a Medicaid recipient, the Department of Children and Family Services should recognize and have a systematic approach to identifying these cases. In such case, the surviving spouse should be required to pursue their rights. This may generate assets to be used to pay for care privately. The failure to do so should be treated as a transfer of assets which may disqualify the resident for continued Medicaid eligibility.

O. Pursue Estate Recovery. Usually Medicaid recipients do not own assets other than exempt assets such as a home or automobile. However, in some instances there are noncountable assets that would be subject to estate recovery upon death. The state should identify and have a systematic approach to seeking recovery upon death when there are such assets. Note, the asset information is known to the state through the application process, it is just not acted upon at death.

(4)

Dear Legislator,

I have been in the Health and Human Services field more than 40 years. I have reared a Down Syndrome Daughter from birth to 33 years and have seen my aged father suffer significantly in a nursing home that failed him in most all respects. Once I was a provider of Medicaid Services but ran screaming in the night for want of a rational word from any direction. Following are my comments on the Medicaid Modernization you will be considering. Bear with me as my patience is stretched.

1. Where will all the five star service providers come from? Who will do the marketing to develop new providers because former providers are disenchanted with Medicaid payment systems and frequent changes? I used to provide services but never again.

2. Will the new "Medicaid Savings Accounts" accrue interest to the consumer owner or to the State if not spent or held until needed?

3. If a client uses Catastrophic Funds will this draw down on the Medicaid Savings Account and if so how will the primary account ever be reinstated?

4. Most recipients of Medicaid benefits are poorly prepared to made informed decisions about spending for their health care needs in a preventive fashion. Moreover, they may not have the ability to predict future health needs. So, who provides decision-making and management choices assistance to such clients as not all have family members or active guardians?

5. The State says with the new plan it can predict growth in the health care needs. The only way to predict growth in virtual health needs growth is to establish spending limits and regressive eligibility requirements. Lets not play games. Most of us beyond the 6th grade level understand that when States are broke, spending limits must be set. Lets start out by telling the truth to one another.

6. As noted, the Principles of Medicaid Modernization Statement as written is a political document, or better still, a wish list without measurable objectives. There are no facts or figures, and consumers and advocates alike need to know what discrete program choices available, how many are on the menu, and in what ways are new program choices superior and more flexible than previously available.

7. How will "Persons insured through Medicaid be taught to use of the Medicaid resources in accordance with services allocated on their behalf"?

8. Define "new flexibility" and state how it ensures diversification, innovation, and improved service with better value? These are not measurable concepts but rather sales propaganda.

9. Service caps and expenditure limitations are mentioned without concrete or projected numbers. Thus no one knows how many services will be available and the cap costs. Why not send out a summary sheet with a sample of programs and program spending caps?

10. What is the formula used for determining the average historical evidence for costs?

11. Please send out a comprehensive, nuts and bolts program write-up with fiscal accounting plans, forecasts, anticipated client population profiles, and include Medicaid Modernization provider licensing criteria. Then, you may expect a reliable and informed critique.

Mr. And Ms legislator, please do not vote mindlessly. Tsunamis happen here in America and take many forms including Continual Medicaid reform. If Florida honestly wants clients and caregivers involved in the decision making process, send us something we may respond to intelligently. As of now it is politically clear that our country is a faith-based nation of people. However, our faith appears to be more based on preserving the dollar over the consumer.

Small wonder that a gray malaise shrouds those of us who have been in public health and human services more than 40 years. We have seen it all recycled several times. Every "new" package is tied in as bright a ribbon as money will buy to dazzle the reviewer's eye and to razzle-dazzle the consumer group.

Dr. Mary Sixwomen Blount, Ph. D., LCSW

Principle Chief and Health Officer

Apalachicola Band of Creek Indians

Texas, Oklahoma, and Florida

Dear Congressman:

I would like to take this opportunity to introduce myself to you. My name is Deborah Fraze, MSN, ARNP, Vice President Clinical Services for Pediatric Health Choice. Pediatric Health Choice is a leading Medicaid provider of alternative site health care services to children with complex medical needs, and we are the largest operator of pediatric day health centers (Prescribed Pediatric Extended Care: PPEC) in Florida.

After having attended Tampa's Joint Regional Public Hearing on Medicaid Reform on Friday, February 11, 2005, I regret to tell you that due to the overwhelming number of presenters and subsequent time constraints that I did not get an opportunity to speak. My purpose for attending the hearing was to heighten the committee's awareness of an innovative healthcare service delivery model that already exists in the current Medicaid Program, which if suitably utilized would unequivocally save the State of Florida's Medicaid program hundreds of thousands of dollars annually.

I am compelled to provide you and the committee with this information because I am confident that PPEC is the "undiscovered" catalyst for reducing the rapidly increasing cost of private duty nursing while continuing to provide needed quality services for special needs/technology dependent children in the State of Florida.

Thank you in advance for allowing me to express my views and for reviewing the attached document.

Dear_____,

Thank you for your interest in Medicaid reform. I appreciate your willingness to participate.

In announcing the formation of the House Select Committee on Medicaid Reform, I charged the committee with the task of analyzing the reform plan proposed by Governor Bush, listening to suggestions from the public, and working with the Senate and Governor's Office to evaluate the options available for Medicaid reform.

The purpose of the regional public hearings being held throughout the state jointly by the House and Senate Select Committees on Medicaid Reform is to gather information from providers and Medicaid recipients who may be affected by changes to Florida's Medicaid program and to collect innovative ideas on ways to reduce the rapid growth in Medicaid costs while continuing to provide needed services to Florida's most vulnerable citizens. If we're going to solve this problem, we're going to need a lot of help. The select committee will allow us to hear from Medicaid recipients, providers and experts as we search for the best solution for everyone involved.

Significant numbers of interested parties have attended the joint public hearings held thus far. In spite of necessary time limitations, the Chairs of the Select Committees have made every effort to provide each person wishing to speak the opportunity to do so. At each hearing held to date, members have remained in the meeting room beyond adjournment in an attempt to afford additional persons the opportunity to provide input. Additionally, the committees have accepted and welcome written testimony from anyone wishing to submit comments. Your comments have been forwarded to the Select Committee for their review.

Thank you for sharing your concerns and for your willingness to contribute to our efforts to reform the system and improve access to services for our most vulnerable citizens while reducing the unsustainable annual rate of growth in spending in the Florida Medicaid program.

would like to take this opportunity to submit in writing my recommendations for Medicaid reform. I know your committee is meeting in five ties in Florida, but unfortunately none of the cities where the meetings are taking place is close to my home. I feel the need to provide testimony ecause a great number of families and elders that would be impacted by the changes in the Medicaid program reside in Miami-Dade County here my family resides. As a matter of fact, a great number of them are in your own district, Hialeah, and because of the logistics and cost of avel to the meeting places their voices will be absent. I therefore decided to present this testimony so that the people that elect you to represent iem in Tallahassee will have a mechanism to have their voices heard in this process.

agree with the general feelings that Medicaid needs to be improved, but after serving in the capacity of Secretary of the Florida Department of

lder Affairs for almost three years I have a different perspective as to what needs to be done. I offer my recommendations in the hope that the ıost vulnerable citizens among us could be spared the pain of suffering unnecessary health risks and chronic conditions, including premature ɜath. The Medicaid recipients are the victims, not the abusers of the system. The Medicaid program is running out of control not because frail ıildren and families are taking advantage of the program, but because the program has been designed to be the dumping ground of companies ıd government who offer no health insurance to its workers. This practice, I am sad to say, exists in Florida where thousands of workers are laced on OPS status beyond what the regulations provide they should be, placing them and their families in a world without benefits and health ısurance.
hese are my recommendations:

) It is my belief that in order to reduce Medicaid costs we need to open Health Care coverage to the working poor. As long as private ɔrporations are able to exclude Health Care coverage from their benefit packages or are unwilling to absorb a greater portion of their employee ɜalth care costs or are able to classify full time workers as consultants, or OPS workers to bypass providing health coverage, Medicaid will ɔntinue to be the only health care choice for the working poor. As such, the Medicaid budget will continue to increase because there are more orking poor in Florida today that there were six years ago. To reduce Medicaid costs your committee should recommend that private ɔrporations and government agencies offer health care coverage to their workers. This includes OPS workers in your own office and throughout ıe State of Florida government. This will begin to shift the cost from Medicaid to the appropriate entity and not to the working poor or frail lults.

) The cost of prescription drugs is also contributing to increases in the Medicaid budget. The attempts by the state to negotiate directly with ıarmaceutical companies who contract with Medicaid have failed to generate any real savings. The State of Florida and the Agency for Health are Administration have failed to control medication costs because we have allowed the Pharmaceutical companies to be in the driver□s seat of ıose programs and those negotiations. In a report published by the Ft. Myers News Press, a program sponsored by Carole Green and designed tc ɜduce the cost of medication resulted in a higher overall cost for medication because pharmaceutical companies were allowed to recommend to ıe clients their own medications to deal with a variety of illnesses.

the cost of Medication is an important financial factor, why do we continue to oppose the re importation of safe and secure prescription drugs om Canada? What is wrong with buying medication made in New Jersey or Puerto Rico at 55% of its cost? It is clear that the Governor□s ɜcommendation to cover only the least expensive medication for a given condition is going to deny the working poor the option to live. By ɜfault this creates an artificial selection of who should live or die based purely on income. Before your committee begins to explore the rationin; f medication by deciding to only cover medication that has the lowest cost for a condition or disease, your committee should think of passing gislation approving the re importation of Canadian and European prescription drugs. The future of our children and our families are at stake, an(ledicaid should be allowed to obtain the newest FDA approved medication for the illnesses of the Medicaid participants from a licensed and ɔproved pharmacy in Canada, Israel or Europe. This is a matter of life and death and life or death should not be decided by income levels. I ɜcommend that your committee support the Pharmaceutical Market Access and Drug Safety Act, a bipartisan legislation introduced in /ashington HR 238 designed to address the issue of drug re importation.

) Medicaid is one of the main payers of Nursing Homes. Therefore, if we want to reduce the Medicaid budget we should also look at properly ınding and supporting Home and Community Based options. This is to include Assisted Living Facilities, Group Homes and Consumer Directe(are programs. The cost savings of switching more funding to the above mentioned categories have been well documented and presented to the ledicaid Joint Conference Committee for years. The numbers are there, all you have to do is to begin to properly fund programs that will not onl ıve costs but avoid costs. Continue to expand and support the Nursing Home Diversion Project with the same emphasis we gave the program in)99-2001.

) In 1998, Florida won a victory against the Tobacco Industry. The main reason we Floridians received such a large award was because under th adership of Governor Chiles we documented the relationship between the use of Tobacco to increases in the health care costs, particularly to the ledicaid budget. A trust fund was set up to help offset the Health Care costs. By default, it should have also helped offset the Medicaid budget. my recommendation that your committee track down what has happened to the Lawton Chiles Tobacco settlement and use the money to help ffset the Medicaid budget and to set programs to further prevent the detrimental effects of Tobacco products on our children, families and elders

) It is clear that another important component of the Medicaid program is the providers it contracts for services. While a great number of ·oviders are doing what they are supposed to do, some of them are not. Medicaid has been poorly monitored for years. The contracts have been ıarded to politically well connect agencies rather than agencies that are truly meeting the needs of the individuals in a cost effective fashion. lonitors have been afraid of reporting what they have observed for fear of losing their jobs. Politicians□ interference has given providers an ɔen door to commit a variety of abuses from fixing prices, double billing and the creation of monopolies, all with Medicaid funds. If your ɔmmittee is serious about fixing Medicaid, I recommend your committee protect those monitors from political pressures and allow them to do ıeir job. Set regulations that if □billing errors□ are found resulting from double billing for the same services to two different agencies, billing fc ɜad clients, billing for services that were never delivered and price fixing of unit cost, that providers would lose their Medicaid provider□s ımbers and not be allowed to bid for other government contracts for a period of three years or until there are reassurances from the Board of irectors that the persons responsible for such improprieties are no longer employed at that agency.
ıclude in your regulations that if an agency is fined a penalty for handling one government contract, that agency should be not allowed to

ntinue with any Medicaid contract, including Managed Care Medicaid contracts.

) Personal responsibility comes in many forms, from saving money for a rainy day to paying for our long term care. If Medicaid is to be formed, we must also address the number of Medicaid recipients that have diverted their income to other family members to artificially qualify r Medicaid services. To be fair reforming Medicaid should include the collection of money from those beneficiaries that have been involved in e creation of the so called □Medicaid Trust funds□. This effort should be an integral part of the solution.

) Every $1 a state spends on Medicaid attracts $1 to $3.27 in federal matching funds, most of which goes to support local hospitals, clinics, ysicians, nursing homes, pharmacies, and other health related jobs. Medicaid helps support employment by a wide range of health care rsonnel, ranging from physicians to nurses to less-skilled, low-wage employees like nurses' aides and home health workers. The income these orkers receive enables them to pay mortgages and rents, buy food and other goods, and pay taxes, thereby contributing more broadly to state an cal economies.

he impact of Medicaid on state economies, particularly the impact of federal matching funds, has been confirmed in three separate studies nducted by university-based researchers in the last year. The studies consistently found that deep cuts in state Medicaid programs can trigger th ss of thousands of jobs and reduce state economic activity by as much as hundreds of millions of dollars. Moreover, since the health care oviders that Medicaid supports are spread across the state □ in urban and rural areas alike □ the repercussions of these cuts would be felt atewide. These economic effects, of course, are in addition to the reduction in health coverage and services that Medicaid cuts would inflict on w-income households the majority of them residing in our home district of Hialeah. Therefore be aware that serious cut in the program will hav detrimental effect in the economy of our State.

s long as the government of the State of Florida keeps workers on OPS status indefinitely, as long as private companies receive no rewards to ovide health care options to all its workers, as long as providers are able to intimidate monitors and financially take advantage of the program, id as long as wealthy families are able to avoid paying for their elderly relatives□ long term care needs, Medicaid will continue to grow at a pac ster than our ability to pay off its costs.

hank you for the attention you provide my recommendations. I am willing to help in the search for a solution. I continue to be committed for th ell being of families, children and elders.

ema G Hernandez, D.P.A.

February 21, 2005

Gema Hernandez
3536 Gardenview Way
Tallahassee, FL 32309

Dear Dr. Hernandez:

Thank you for taking the time to write to me regarding your recommendations for Medicaid reform. As you noted we have established a House Select Committee which is holding hearings around the state to solicit input from individuals and groups who will be impacted by potential changes in the program.

I am sorry that you are not able to travel to provide testimony at any of the hearings - just in case, however, the hearing closest to you will be Next Friday, February 25, 2005, from 12:00 p.m. – 3:00 p.m. at the Gulf Coast Community College in Panama City.

I am forwarding your comments to Representative Holly Benson and Representative Joe Negron, who co-chair the House Select Committee on Medicaid Reform, so that the members may include your information in their deliberations.

Sincerely,

Allan G. Bense
Speaker

7

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately $14.4 billion (24% of the entire state budget) and are projected to more than double to $36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. If you wish to mail this form or email your comments, please send to:

Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Maureen Murphy

Association: Florida Renal Adm. Assoc.

Address: 203 Executive Ct.
Orlando, FL. 32801

(*Please use the front and back of this sheet to provide your information.*)

See attached statement on ESRD funding issues.

Florida Medicaid ESRD Program Misunderstood And Poorly Funded Causing Inappropriate Use Of AHCA Funds

Florida Renal Administrators Association

Current Situation

At any point in time there are approximately 675 Medicaid eligible patients who have kidney failure and need outpatient dialysis treatments in the State of Florida. These patients are either waiting to become eligible for Medicare or will **NEVER** be eligible for Medicare due to no work history and do not qualify under a spouse or parent.

These 675 patients are referred from hospitals to the approximately 280 outpatient dialysis facilities in the State. There are less than 6 hospitals in the state that continue to offer outpatient dialysis services.

Currently, Medicaid pays $85.00 for a hemodialysis treatment performed at freestanding outpatient facilities, allowing three treatments per week. A prorated amount of $36.00 per day is paid for a home peritoneal dialysis patient dialyzing seven days a week. The only other service paid to dialysis facilities is for Epogen, an anemia medication.

I. Improve Access To Care For Medicaid ESRD Patients

- ESRD Patients are currently being denied access to free standing facilities causing increased costs to AHCA due to extended Hospital Lengths of stay. Florida's Medicaid Program only reimburses $85.00 per Dialysis treatment, the lowest rate of any US state Medicaid ESRD program. This rate must be increased to at least the average Medicare rate as of 4/1/2005 of $150.00 per treatment. Med PAC's report to Congress in 2004 stated the Current ESRD Medicare rates only cover 98% of the costs of providing the treatment; the Florida Medicaid rate only covers 65% of the cost. The Medicare treatment rate is to increase by 1.6% January 1, 2005. Florida Freestanding facilities can no longer absorb the loss of $50/tmt, or approximately $10,000 loss per year per Medicaid ESRD patient.

- Expand the Medicaid formulary to include Vitamin D analogs, injectable iron and other ESRD therapies to be more aligned with the CMS ESRD Medicare formulary. Currently Medicaid ESRD patients are not receiving these medications, which leads to increased risk of hospitalization, morbidity and mortality.

- Establish a Medicaid outpatient reimbursement rate for blood transfusion services; currently patients are hospitalized unnecessarily for transfusion services.

- Allow illegal aliens with ESRD to receive Florida Medicaid without having to qualify through the Emergency Medicaid program. This program was not intended for ESRD Patients, qualification is a very lengthy process, delaying admission to outpatient facilities and increases cost of hospitalization.

II. Exempt Medicaid ESRD Patients From Single Vendor Laboratory Proposal And Support Physician Choice To Select Laboratory Services Of Their Preference

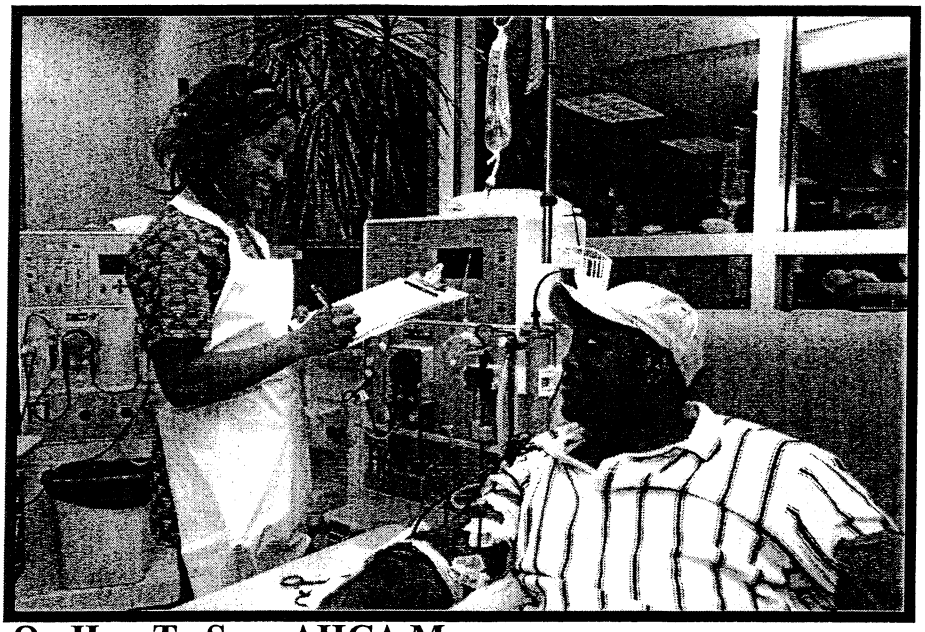
- CMS requires dialysis facilities to report facility specific aggregate quality indicators of all ESRD facilities; this cannot be achieved if lab for Medicaid ESRD patients is mandated to a single lab provider. This will fragment the dialysis facility's ability to trend and track quality of care indicators and would compromise the integrity of the aggregate lab values, as well as causing increase administrative cost to comply with such a mandate.
- Referring nephrologist should be allowed to referred specific lab tests to the lab of their choice, and not be mandated by the State on which lab there are to utilize. Lab work for patients with ESRD is very specific and should be referred to dialysis specific laboratories.

III. Average Direct Costs per Dialysis Treatment

For the $85.00 per hemodialysis treatment, the dialysis facility is expected to provide the following CMS mandated services. Due to high costs of recruiting and retaining nurses, the labor component alone is now exceeding $85.00 per treatment in most Florida areas.

- Registered Nurse and trained patient care technician care for the 4 hour treatment
- Masters prepared social worker services
- Registered Dietitian Services
- Disposable supplies, equipment and overhead for the dialysis treatment such as:
  - Dialyzer – Costs range from $12.00 - $30.00 per treatment depending on the medical needs of the patient.
  - Blood Tubing
  - IV solutions – Saline
  - Needles and syringes
  - Sterile dressing changes for access site
  - Medications such as heparin, mannitol, hypertonic saline, and many others included in the composite rate
  - Dialysis machine and testing equipment
  - Treated water for the dialysis treatment

These are all direct costs on providing each treatment. Other indirect costs include facility's rent, taxes, utilities, housekeeping and medical directorship oversight.



Case Study On How To Save AHCA Money

- Florida Hospital Based ESRD programs are paid a much higher rate than freestanding facilities:

Shands Healthcare System, Gainesville	$203.78/tmt
Florida Hospital, Orlando	$140.08/tmt
St Lukes Hospital, Jacksonville	$145.15/tmt
All Freestanding Florida ESRD facilities	**$85.00/tmt**

- Source AHCA January 2004:

http://www.fdhc.state.fl.us/Medicaid/cost_reim/hospital_rates.shtml

- Example, Shands, in Gainesville, has approximately 25 Medicaid primary pts, if AHCA would reimburse the Gainesville area freestanding dialysis facilities, the average Medicare rate of $130/tmt, AHCA would save $276,675 per year, just in Gainesville!

  - ✓ $203.78 - $130 = $73.78/tmt difference (savings per tmt)
  - ✓ $73.78 x 25 pts (Shands Medicaid ESRD pts treated at freestanding facilities) X 150 tmts/yr =

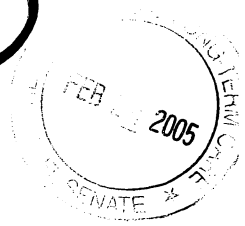
$ 276,675 Savings to the AHCA ESRD Program, and that's just in Gainesville !!

Medicaid ESRD Reimbursement Ranking

	State	Per Treatment Rate
1	Florida	$85.00
2	Alabama	$97.09
3	Georgia	$112.93
4	Maine	$114.48
5	Missouri	$115.00
6	Pennsylvania	$115.00
7	Rhode Island	$116.00
8	Mississippi	$117.00
9	New Hampshire	$117.17
10	Illinois	$121.24
11	South Carolina	$121.44
12	Kentucky	$122.45
13	North Carolina	$124.06
14	Oklahoma	$124.21
15	West Virginia	$125.40
16	Louisiana	$125.70
17	Connecticut	$129.88
18	Arkansas	$130.00
19	Kansas	$130.00
20	Indiana	$130.91
21	Ohio	$131.37
22	Hawaii	$131.39
23	Nevada	$135.41
24	Maryland	$136.17
25	Virginia	$138.00
26	California	$141.31
27	Michigan	$148.43
28	New York	$150.00
29	Washington	100% U&C

New Jersey	Medicare
Texas	Medicare
Massachusetts	Medicare
Wisconsin	90% of U&C
Tennessee	Medicare
Delaware	Medicare
Colorado	Medicare
New Mexico	Medicare
Arizona	Medicare
Oregon	Medicare
Minnesota	Medicare

8



The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
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The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

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Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Sheryl Lyons

Association: Children's Home Society of Florida

Address: 3270 Suntree Blvd., Suite 100
Melbourne, FL 32940

(*Please use the front and back of this sheet to provide your information.*)

I am advocating for children's community mental health + targeted case management services in Florida. Both children in the community + children in the child welfare/dependency system currently benefit from an array of community-based mental health + targeted case management services that allow

them to become healthy, functional individuals — they will lead us in the future, & the investment in them now is key. With the newest revisions to AHCA's community mental health services handbook, ITBS services were collapsed into TBOS services, with a 50%-plus cut in the number of this service that a recipient can receive. If mental health services are capped or cut, there will be higher rates of residential treatment stays (currently provided thru SIPP programs), longer waits to access SIPP beds, & more Baker Acts of children waiting for SIPP beds. More children will enter the child welfare/dependency system due to their caregivers being overwhelmed & unsupported due to restricted services/medications. Last, more children will require more costly restrictive exceptional education settings, due to the lack of services & medications in the community, leading to higher expulsion & dropout rates. All of these outcomes result in higher, shifted costs, not a resolution to the problems.

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Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Susan Shupert Lara

Association: Legal guardian Martha Shupert

Address: 713 E. Monroe St.
Apopka, FL 32703

(*Please use the front and back of this sheet to provide your information.*)

Please see letter attached

Susan Lara
713 Monroe St.
Apopka, Fl. 32703
407-889-3456
Email- sshupertlara@aol.com
2/8/05

Pg. 1 Regarding: Martha Shupert

I would like to tell you about someone who is very dear to me, who has taught me sometimes life, is not fare but fight for what you believe. She taught me the power of the family unit and how it is very precious, but most of all a bond that can never be broken. This person is my mother.

Martha Shupert is 76 years old and is at the end stages of Alzheimer. She has always been an active member of her community and church while raising 6 children and standing side by side with my father building a business.

She always gave 100% in everything that she did and still had time for each one of her children. That is why I am writing to you for your assistance so that I may keep my mother safe from any harm .
In 1997 after the loss of my brother, my mother started changing forgetting things and withdrawing. My family knew that something was wrong so we took her to her Physician and was told that she was in the early stages of Alzheimer. The family took the news hard and we were all at a loss because mom had been the foundation of our family. We decided that I, my sister Shirley along with daddy and my husband would take care of mom no matter what it took. . In 1999 our family lost my other sister Brenda to cancer and that seem to take my mother down even more. It was like she knew something was different now, Brenda was gone and I could not tell her because I did not know if she would understand. Right now my mother was still a comfort for me with my sister's death. She was still smiling and giving me signs that she was still there. I do not know how she did it but there was a time that she could wipe a tear from my face and give me comfort in her arms just as I remember as a child.

In November 2003 my mother had to be placed in a nursing home due to the fact I had put so much into taking care of her that I did not realize I had lost myself in her illness and became ill myself. I spent 3 weeks in the hospital and nearly died myself. I had to have 3 transfusions, diagnosed with ulcerated colitis, Irritable Bowel Syndrome and the lining of my stomach had been eaten away from a virus that I was skin and bones and could not eat without vomiting. While this was going on my sister Shirley also had to have surgery on her back because of Osteoarthritis and having to lift mom again took its toll on our bodies and didn't know it A donor bone had to be fused in her back which crumbled after that more problems occurred with her until she could no longer help with moms care.

As you can imagine we could not care for our mother and daddy could not care for her on his own, We decided to placed her into a nursing home and that is when things started getting worse. After being in the nursing home for 3 days we were called to the hospital. My mother had been brutally beaten by another Alzheimer patient.

Seeing my mother like that was horrifying, she went further down hill. She went from walking, talking and still smiling to no more walking or talking and incontinent. Now she has to be fed and handled 24/7. It is so hard on us but we attempted to place her again in another nursing home. During which time my father past away. That added to our family's pain.

In the next nursing home for almost a year and I thought that we had finally found a place where mom could spend her days in peace well that was not the case. I started noticing bruises on her arms and her roommate would mention that my mother was being treated mean. When I asked about it they would brush it off. The bruises would last for 3 weeks and I complained. On December 10, 2004 I received a phone call from the charge nurse that my mother who could not tell me anything had been sexually molested by another

Alzheimer patient. Why was this happening to her again? Why?

Pg 2 regarding Martha Shupert

The woman who taught me to fight for my loved ones had been let down again. Again the system let me down as well. I am disabled now and I had to bring her home to live with me. I can not take care of her in the manner that she should but I struggle everyday to make sure she is clean, fed and comfortable but most of all, SAFE! I am sick all the time due to the toll my body has to take in keeping my mother safe at home.

What I am asking is some kind of help. I have called every resource that has been given me and nothing is there for me. I have hired an agency to come in 2 days a week and it takes all of my mothers Social Security check just for those 2 days. I look forward to those 2 days but I am unable to take time away because the Home Health Aide can not administer her medications and so I am bound to the house and I have to be up with her every 4 hours during the night.

All I am asking is if it is possible to pay a Nursing Home her Social Security check and additional amount of 4000 dollars then why can it not be possible to pay that additional amount to an agency so that I can keep my mother at home so she can have 24 hour nursing care? How would you feel if it were your mother looking at all bloody after a beating and finding out they cleaned her up before they took her to the hospital. I know that is an old cliché (what if?) You can not be upset for me trying to fight for my mother. To keep her comfortable in her last days, this could be another 7 years. Who knows? That is the one thing about this disease, you do not know. You don't know when.

I have become so afraid about nursing homes and with my illness it just makes things worse. Is there anyway that her Medicaid be revised so that she can stay home and get the care that she needs? I am afraid that if this keeps up that I will not be alive and then where will she be? I can not keep this up and I have been told by so many people within this system that a nursing home is the only way and I cannot do anything about it, it just won't happen. I cannot believe that this country can be so giving to victims outside our borders but not so caring or giving to our own at home.

Will you please find it in your power just to see if this can be done? I am not asking for the money to be sent to me but to the agency itself. Right now it is taking every bit of strength that I have and my husbands to make sure that she has everything she needs and now his back is losing the fight in taking care of my mother. Between myself and my mom my husband can not even work. It is sad when people are in that stage of in between and no one will help or the need is so great and not enough money or our government says you don't qualify. Why?

See I was told that this would be useless to do, but I chose to do it anyway. I still believe that things can be done for the good and that is what I am asking. Make a difference in the time that she has left. And hopefully if it cannot be resolved in my lifetime then maybe it will be in my grandchildren's. Thank you for consideration and your time. Hope to hear from you soon.

Sincerely,

Susan Shupert Lara

PS UPDATE WENT TO THE NURSING HOME MANOR CARE TO SEE MOM THIS SAT 11 AM EVERYONE ELSE UP IN ACTIVITIES. NOT MOM STILL IN BED NEVER BEEN DRESSED OR GOTTON UP. Seemed to have not been given meds yet I could tell by the way she was twitching and uncomfortable . Dried poop under her nails. Her nurse was on lunch break, she shouldn't have went on break till all her patience at least had the am meds agree.CNA standing in hall way, says she will get mom up next she has to give some one across the hall a shower first. Please can you help us I cant handle the

emotional roller coaster of all this anymore. I just wish mom could talk so she could raise hell and FUSS enough that she would get care just to shut her up. But you see she would never ask for anything when she could talk afraid she was being a bother. Please call or write me asap my home # is 407-889-3456 and cell 407-641-1527 address 713 E, Monroe Street, Apopka, Fl. 32703 Thanks in advance Susan Lara
2/15/05 UPDATE BEEN IN HOSPITAL WITH MY HUSBAND WHO HAS HELPED ME CARE FOR MOM SINCE DAY ONE THE SYSTEM MADE US AFRAID NOW HE HAS 10 BULGING DISC AND SOME NERVES PINCHED AND BLOCKING SINGNALS TO SOME OF HIS BODILY FUNCTIONS.WE WERE TREATED TERRABILY AT THE HOSPITAL A 26 HR ER WAIT ON A GURNEY BESIDE THE WALL. BESIDES THAT HE WAS RELEASED BECAUSE HE HAS NO HEALTH INSURANCE. AND THAT REASON IS BECAUSE THE JOB HE PREFORMED WAS TAKING CARE OF MOM NO HEALTH INSURANCE BENEFITS COME WITH THAT.
THANK YOU , SUSAN LARA

UPDATE SAT. FEB 18, 2005 MY HUSBAND IS REALLY ILL DUE TO WHAT ALL WE HAVE HAD TO ENDURE. He really needs to go back to the ER TONITE but 7 weeks of daily visits he says he just cant bear it. He has formed a fistula absess that will require surgery. And the treatment we receive is just terrible. He said if a animal was in this much pain, the vet would give it a shot to put to sleep and out of misery. But a little bedside manner can sometimes go a long way, Instead being judged and looked down upon because of know health Insurance.
THANKS SUSAN LARA

Martha Shipett

ManorCare of Winter Park

Room Rates

Private Room: $5580.00 per Month

Semi-Private Room: $4960.00 per Month

Three Bed Room: $4836.00 per Month

Prices include; room and board, bed maintenance, daily housekeeping, 24-hour nursing care, cable, dietary services, social services, activities and routine supplies commonly used by most residents.

Additional costs may include; wound care, incontinent, laundry services, transportation, nutritional supplies and specialized equipment as ordered by physician.

If Medicare & Medicaid would give this amount to a agency I could have 24 hr. nursing at home for mom and oversee her safety.

(10)

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately $14.4 billion (24% of the entire state budget) and are projected to more than double to $36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. If you wish to mail this form or email your comments, please send to:

Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Beverly C. Towles

Association: member of NAMI National Alliance for Mental Illness

Address: 2410 Mohawk Trl.
Maitland, FL. 32751

(*Please use the front and back of this sheet to provide your information.*)

For the past 10+ yrs. our son, Rob has been stabilized on his prescribed Zyprexa, trazadone and risperdal. It is only because these medicines, which are prescribed for his paranoid schizophrenia, that he is able to work have his own apt. and automobile

and be a contributing & responsible citizen.
I plead with the legislature to please not
take away his means of having a fairly
normal life. Unmedicated, he will become
homeless, violent and sick and perhaps an
easy target for street criminals. Conlin,
primitive medicines like Haldol, etc. were
so loaded with side effects that he virtually
couldn't function at all. We, as a family have
been through the initial nightmare of his
only medicine. Please don't take away his
chance of maintaining a decent lifestyle and
some peace of mind for his family. He is 45
yrs. old & has maintained a good job at Publix
supermarket for 5+ yrs. with an excellent
record. He has regained a sense of self-respect
It would be tragic to take that away. As
law-abiding citizens we hope you will
make the right decision for our son and
thousands more like him.

Sincerely, Beverly Fowler

GEORGIADES.CELIA

From: Liberty County Transit [libertyt@gtcom.net]
Sent: Thursday, March 17, 2005 9:27 AM
To: MEDICAID
Subject: Medicaid Non-emergency transportation

We at Liberty County Transit think that the non-emergency medicaid transportation should remain a seperate contract.

We believe the way the non-emergency medicaid transportation is being handled now is the way it should remain. The Commission for the Transportation Disadvantaged deals with all types of transportation and they are doing a wonderful job with the medicaid non-emergency transportation.

Sincerely, Brenda G. Clay, Executive Director

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GEORGIADES.CELIA

From: Wlrdpm@aol.com
Sent: Thursday, March 17, 2005 9:59 AM
To: KLEIN.RON.WEB; MEDICAID
Subject: MEDICAID FRAUD AND ABUSE

Ron,

As you requested input on this subject , I can only say that fraud and abuse has been going on in Florida much too long.

More stringent , but fair guidelines and enabling actions must be adopted.

Bill Reider

13

GEORGIADES.CELIA

From: Winegar, Sandra [SandraWinegar@polk-county.net]
Sent: Wednesday, March 16, 2005 4:07 PM
To: MEDICAID
Cc: * PUBLIC RECORDS *
Subject: Medicaid Non-Emergency Transportation

Medicaid Non-Emergency Transportation (MNET) needs to remain with the Commission for the Transportation Disadvantaged and not under the oversight of a Managed Care Organization. MNET has historically been considered part of the coordinated transportation system and that must remain intact.

Please vote to keep tranportation under the oversight of the Commission for the Transportation Disadvantaged!

Sandra Winegar
(863)534-5301

GEORGIADES.CELIA

From: O'Brien, Deanne [DeO'Brien@mhs.net]
Sent: Wednesday, March 16, 2005 11:29 AM
To: MEDICAID
Subject: Funding Cutbacks

Honorable Congressperson,

I understand Medicaid is threatened with cutbacks.
The support center where I often go and fellowship with like minded consumers would be greatly affected by these cutbacks.

This would especially be felt in the area of medication.
Many of these individuals have not other source of income or health insurance.
These medications help keep us going and functioning.
Without Medicaid it is likely many more of these consumers would require hospitalization, a far more expensive alternative.

Thank you for your time,

Sincerely,
Nancy Petroski

GEORGIADES.CELIA

From: 1 [Kgriffin7@cfl.rr.com]
Sent: Sunday, March 13, 2005 11:53 PM
To: MEDICAID
Subject: Medicaid Modernization

Dear Committee Members,

I am writing to you as the parent of someone with a severe disabling mental illness. We know first-hand that psychiatric medicine is not an exact science. Finding the most effective treatment for an individual may take months or even years, but once found, it make make the difference between life and death (by suicide), or the difference between a productive life in our society or a burden to society by added hospitalizations and /or incarcerations. These individuals deserve the best treatment options avialable to them. That may mean a more expensive drug, but in the long run the treatment that works would be the most cost effective. We hope that one day there will be cures for these various brain disorders, but until then, we hope for stabilization and optinmal treatment, the same one would want for a diabetic or hypertensive patient. So Please, do not restrict the Medicaid Drug Formulary. To do so would sacrifice the well-being of thousands.

Sincerely,
Kathy H. Griffin

GEORGIADES.CELIA

From: Charlotte Lavergne [clavergne@direcway.com]
Sent: Tuesday, March 15, 2005 9:07 AM
To: MEDICAID
Subject: Medicaid Reform

I agree that Medicaid needs to be reformed. However, I do have concerns when it comes to the providers that treat the recipient's of Medicaid.

I am a billing center for many providers. The provider's population for the most part is referred from the Early Intervention Program. Currently recipient's have a choice of either being Medipass or HMO (Healthease). The patients that have chosen the HMO cannot be seen because they are not in network with Healthease. The providers (mostly individual not groups) are not allowed to be in their network beacuse the network is NEVER opened for open enrollment.

If Medicaid goes to Managed Care, will the insurance carriers that are given the contract for the managed care be forced to allow more providers in their network.

If the HMO's are not going to open their network, this could put A LOT of providers out of a job (individual providers) or cut their patient load severely. What happens then? Will they be forced to go to work for someone else because they cannot get in network with the insurance carriers?

GEORGIADES.CELIA

From: Jack Bobeck [jbobeck@filingsource.com]
Sent: Tuesday, March 15, 2005 10:11 AM
To: MEDICAID
Subject: Opening Access to the Medicaid System

I attended the recent meeting in Jacksonville, by the Select Committee on Medicaid Reform. I agree with many in the room that it is a huge task and I thank the Legislature for taking the time to listen to public opinion and for looking for solutions. Something our company has done here in Jacksonville with the Area Agency on Aging is to streamline the collection of data through the use of ID cards and scanners. The ID Cards are used to allow Seniors of Duval County to ride buses and use other means of transportation. In addition, they can use the card to check out books, but most importantly, the managers of each of the Duval County Senior Locations can use the barcode on the front to capture the services provided to that person.

For your application, imagine ID cards with a Florida Sunshine Number (no real value except that it is tied to the FLORIDA or CERTS system in Tallahassee) that could be used at any hospital, pharmacy, clinic, and provider in the network to receive services. Their barcode number could be used to run reports on services and possible spending accounts could be tied to their barcode number. The City of Jacksonville, Adult Services Department has said that this barcode system allows them to eliminate waste and most importantly, spend more time with the people they are assisting. Using technology has also allowed them to cut their staff as now no one is needed to take the vast pages of paper and transform data into an electronic format at the end of each day.

The State of Florida Department of Elder Affairs has a Senior Card called Waves that provides discounts to Seniors for drugs, but it could be so much more with the assistance of technology. I understand that DOEA has asked Area Agencies to open up access points for seniors to receive services, but the Agencies have been given no budget for this effort. If a scanner were placed at the access points, tied to the system in Tallahassee, all of the data could be collected and monies allocated to the system would be justified.

These are my tax dollars at work as well and I am happy that the local solution is working and helping to eliminate waste. We need more solutions that provide accountability and eliminate waste. I would be more than happy to show members of the Select Committee on Medicaid Reform the local system as would any member of the Adult Services Division here in Jacksonville, please let me know how we can assist you.

Thank you,

Jack Bobeck
Filing Source, Inc.
7529 Salisbury Road
Jacksonville, FL 32256
904-421-3886 phone
904-398-0093 fax

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The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

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Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

FL SENATE ★ HEALTH, AGING & LONG-TERM CARE ★ MAR 1 1 2005

Name: B Ms. Eve Barbour
40 Bayberry Br
Casselberry, FL 32707

Association: President NAMI Greater Orlando

Address: 407-830-4216

(*Please use the front and back of this sheet to provide your information.*)

As you may know, NAMI works tirelessly to make people/services connections. We currently have no cure for mental illness, but we do have treatments. One of the biggest challenges to families with mentally ill loved ones is to find treatments that work and then

Keeping their loved ones on the medications. If Medicaid is tampered with, millions on medications and their families and their communities will suffer.

Please hold us in your hearts & minds as you decide. Our future is in your hands.

Sincerely

Eve Barbour

GEORGIADES.CELIA

15

From: Mike Hendry [Midweho@hotmail.com]
Sent: Tuesday, March 08, 2005 10:59 AM
To: MEDICAID
Subject: Proposed Medicaid Reform

March 8, 2005

I read this morning's Tampa Tribune Metro Section, with a great deal of appreciation, that the Medically Needy portion of the state's Medicaid program is due to be funded in the new state's budget. I wish to express my gratitude to those in the Legislature who spoke out for this, and hope that you were among them, but I also realize that this is only one battle in a larger war.

Everyone has a story so I will not dramatize mine here. I will only state that a portion of my condition was acquired in the workplace as a Nurse for over 22 years and in Healthcare in general for 30 years, and The remainder was acquired in an attempt to assist my mother maintain the quality of life she enjoyed when my father was living. I was not out rock-climbing or motorcycle racing or some other preventable threat to my health. I am, for the foreseeable future, unable to work, which I regret immensely. I have always considered myself a fiscal conservative, and have, within my power kept to that belief with the context of my use of Medicaid as I can, by sticking to my treatment regime and medications in order to maintain the highest state of health that is possible for me. In spite of these actions, I have been hospitalized 5 times in the last 1.5 years and have had numerous doctors' visits that I would have not been able to pay for if those Medically Needy funds were not available.

I feel much luckier that most in the fact that I am a Healthcare Professional and many of the Physicians that I see for various aspect of my care do not normally accept Medicaid in their practice. Before I was in the Medically Needy program, I was in regular Medicaid and was required to select one of the HMO providers offered, which is what the Governor proposes to do for all of Medicaid. The selection process was a fallacy as MediPass was the only program that serviced the area in which I live. And the Providers I found to be well-meaning, but often less knowledgeable about my condition that I had become. The only way these physicians could make their practices profitable, since reimbursement was fixed, was to increase the volume of patients they see.

Certain Parts of this equation, like the reimbursement, are fixed. These physicians must, like everyone that works for a living , make a profit, so they must see as many patients as possible. They must also complete a wide variety of paperwork requirements to receive what payment they receive. Due to their profession, they must drop everything to deal with a crisis, which happens all too often, and can't always be dealt with over the phone. They must sleep to be able to function. And in our society, they should be allowed time with their own families, which as a nurse I can assure you is generally sacrificed to some extent. Just as importantly, Medicine is not a static profession. It is not something you can take the required courses and that's it. It is very dynamic with an extensive need for adding knowledge throughout your professional life to remain effective and competent. This is the part that is most often sacrificed for these physicians.

No one feels comfortable with there physician looking up and instituting a treatment for you he/she finds in a book, and has little or no actual experience, and then consulting the text again when trouble arises. I'm lucky because I have the time and knowledge to monitor and evaluate my treatment and report significant back to my physician, to keep tract of my medications between six different

physicians, and to point out when conflicts arises, and I assure you if it near to being a full time job. But what of the person without the medical background that I have? They are more at risk than just losing financial benefits. I believe they feel their life, and its quality, is a valuable to them as yours is to you. I have worked hard to create my own network within the Medically Needy program where I can obtain the best treatment without increasing costs to the program, but others don't have that advantage. I would like to promote Planned Parenthood and birth control as a way to lower cost to the program, but I have to accept that I am not a Catholic and have to realize a child needs care once it is conceived. So there are no easy answers.

I would love to return to work, more than you know I wish that. But I can't. And I don't expect you or anyone else to feel pity for me, or to hold my hand, or to increase my benefits. And I realize that the cost is of paramount concern to the state. I accept there are aspects of my health I have control over and feel a strong obligation to managing those aspects in a cost effective manner and not squander them. But offering tax breaks to a group of financially sound individuals and businesses at the expense of those who have no other option is not fiscal conservation. It smacks of self interest and even cruelty. No one truly chooses to be ill. This is an issue of survival for the vast majority.

I can only ask that you consider the individual behind every Medicaid number. I would estimate that a good deal of them engages in activities that worsen their conditions and perhaps those are the people that should be evaluated for a reduction in services. The abuser that will not follow the prescribed treatment and continues activities that contribute to their illness is the true threat to us all. Also considering a "Best Practice" model that has become a cost effective part of inpatient care in hospitals over the last several years, in which a group of multi-disciplinary specialists devise a treatment regime for a particular diagnosis, test and revise its effectiveness as necessary, and when the optimal regime is determined, apply the model to entire populations with the same diagnosis. I was involved in several of these efforts in my career, and saw significant improvements in the health of patients, significant savings in dollars spent, as well as identification of those not following the treatment regime.

My point is there has to be a better way of providing for the health of needy individuals and controlling costs. I can assure you that just elimination of funds is not the answer. It will choke emergency departments and hospitals, both of witch are already over capacity, with very sick people requiring very expensive care.

Thank you for your time and consideration of my views

Michael Hendry
3367 Crewsville Rd
Zolfo Springs, FL 33890-2716
(863) 735-0179
midweho@hotmail.com

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GEORGIADES.CELIA

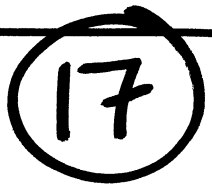
From: ALPHONSO M HOLLOMAN JR [alphonsoh_1@msn.com]

Sent: Tuesday, March 08, 2005 12:59 PM

To: MEDICAID

My name is Alphonso M. Holloman, My adress is 1007 west Madison st. Plant City Fl. 33563. I am writeing on behave of my mother,she is confined to the Brandon health and rehab. with a stroke. I am her caregiver and would like some infor from you on the new bill about Medicaid reform and it ,s privatization. I would love to have detail infoe on what is plan for the patients that are in nursning homes Now and how it will affect them. I will be in Tallahassee on the 21 of March and would love to meet personally with my reps. for this area.thanking you ever so much in advance. Alphonso

GEORGIADES.CELIA



From: NancyAMOMMY@aol.com
Sent: Monday, March 07, 2005 9:35 PM
To: MEDICAID
Subject: Medicaide cuts

Whatever you intend to cut, please don't make the children suffer for it.
They didn't choose to be born with birth defects, illness from whatever-
take it away from the drug addicts and drunks, in fact put them away !

I do my part to prevent wastage and stay out of the emergency room unless the pediatrician says to go or it's a life threatening situation.

Maybe that could be a good slogan for an advertising campaign, PREVENT WASTAGE,
PROTECT YOUR BENEFITS! Putting a hold on supplies when overstocked could pay for a phsyciatric visit to more than the 2 available in the whole city!

GEORGIADES.CELIA

18

From: david zimelman [dzimelman@hotmail.com]
Sent: Saturday, March 05, 2005 1:11 PM
To: MEDICAID
Subject: PLEASE HELP

Please help The cut in Medicaid funds and the availability to get medications is a life and death situation. Think of what the expense would be if I could not get my heart medication, my pscyh medications, my diabetes medications and so forth??? What would the hospital expenses be if I had to go into the hospital because of no medication Please talk to those who are involved hear our stories Do Not deprived those of us who want to take our meds to continue living a normal life and are on disability so Medicaid is our only chance of getting our meds the chance to live. PLEASE HELP

David Zimelman

5600 SW 12 St

N Lauderdale Fl 33068

(954)849-2745

GEORGIADES.CELIA

19

From: O'Brien, Deanne [DeO'Brien@mhs.net]
Sent: Friday, March 04, 2005 1:43 PM
To: MEDICAID
Subject: Personal Recovery Story

Attachments: recovery.doc

recovery.doc (44 KB)

My name is Deanne O'Brien I work at a consumer run drop-in center in Hollywood Florida.
I am active in my community as a mental health advocate.
I am also reasonably educated on legislative issues and vote regularly in all elections.
I am concerned about the changes in Medicaid.
I am particularly concerned about the development of drug formularies that may restrict access to new medications for consumers.
In particular, since I am diagnosed with schizophrenia I am concerned about my fellow consumers being able to access new atypical antipsychotic medications.
Good medicine means good quality of life for those afflicted with this difficult illness.
It is so important that treatment with the best medical treatment available for this illness be available for all those with schizophrenia.
Those enrolled in Medicaid may be particularly vulnerable and be completely disabled by their illness.
I am sending and attachment of my own recovery story.
I would like to put a human face of this illness and the plight of others like me.
We do get better we do recover and we need your support to provide the medications necessary to assist in that recovery.

<<recovery.doc>>
Thank you for your time and consideration...

Deanne O'Brien

I am a consumer; I was diagnosed with schizophrenia 10 years ago. Many people are surprised to here my diagnosis. I hear things like" you don't look like a consumer" and "you seem so normal". It still surprises me how much stigma exists about mental illnesses. People still imagine that a mentally ill person would be dirty or crazy looking.

I am here today as well as I am due to the fact that I have found a combination of medication that controls these symptoms. I believe I am fortunate to have recovered to the extent that I have. I do not feel I am unique. I know many people in recovery from a range of diagnoses, recovery is a reality I see everyday. I believe recovery is possible for all consumers.

I am currently the project director of Rebel's Drop-In Center in Hollywood. At the drop-in center I am a role model and peer mentor; I try to set an example for other consumers that recovery is possible. I remember the days before my symptoms subsided. Every minute of every day I saw manifestations of my thoughts leaking out of my head into other people. I was paranoid, I thought others could hear and see these thoughts. I was anxious a lot. I remember intense emotional pain. I literally struggled to make it through everyday. This did not change overnight, but it has changed.

The process of recovery taught me that it was not just one thing that made me sick. Yes, I have a chemical imbalance in my brain that medicine helps correct. But my mental illness felt more like an emotional illness. I did not know how to take care of myself. I experimented with drugs that did not help. I lost a sister to leukemia when I was in high school and never properly grieved. I moved a lot, I could not keep a job, and the list goes on. In hind site I understand very well how I became mentally ill.

As well, a combination of things has helped me recovery. We are all blessed to have the atypical antipsychotics available to us. It took to the third antipsychotic I tried to find the one that worked. I take zyprexa a newer antipsychotic that is quite expensive. Access to this medication has been very important in my recovery. When I medicine works really well the change can be amazing. My symptoms did not disappear over night, they gradually began it fade away. The symptoms that had bothered me every waking minute one-day stopped. At first for 15 minutes, then 30 minutes, and then for longer periods the symptoms subsided. I was so relieved everything got better then. My mood improved and my anxiety lessened.

I do want to make a point about the importance of taking of medicine. During my first hospitalization I was taught that stopping my medicine was the quickest way to end up back in the hospital. I have been hospitalized twice. I have had two psychotic breaks in which I have stopped sleeping. I hated being in the hospital. I have meet consumers who say they felt safe there, and benefited form being there.

I am not one of those people. Due to the fact I was Baker Acted both times. I experienced that I was being incarcerated, held against my will. I have had horrible experiences in the hospital. I have been put in four-point restraint on numerous occasions. I have also been hog-tied by police officers in transport. I fail to see what is therapeutic about this kind of treatment.

Any of us who have been diagnosed for ten years or longer have probably endured this kind of brutal treatment. Gratefully, there has been a movement in the psychiatric hospitals to minimize the use of restraints. There is police officer sensitivity training to train the officers to show us compassion instead of force.

To come back to my point about the medicine, the way I see it is take this pill, stay out of the hospital, no problem, I will take the pill. I have come to define recovery by different standards. Wellness is not whether or not I take medicine. Wellness is how I feel. Can I do the things I want to do? And I can, I work full time have a nice apartment, a car, and a successful relationship. Having these things, things that would have never seemed possible during the depth of my psychosis is how I define my recovery.

For me the medicine really helped and I take it everyday faithfully. Just because I feel well does not mean that I do not need it anymore either. I have accepted that due to my brain chemistry I have a vulnerability to psychosis that requires me to take medicine.

I taught jewelry making collage and greeting cards at 9Muses, a consumer run drop-in center, for 2 and half years. 9Muses was my real introduction to consumer culture. One of the things I love about drop-in centers and other places where consumers come together is that dialogue that takes place between consumers.

You can talk about meds and side effects ways to cope with symptoms openly. Consumers compare which meds work and what the side effects were like. Sharing these insights I have found very destigmatizing. It is very empowering also to realize that others have had the same issues you deal with. You are not the only person to suffer from a mental illness.

In a Drop-In Center there is an environment of acceptance. It is "safe" to have a psychiatric diagnosis. We all have experienced some form of discrimination because we exposed our psychiatric problems to the wrong person. I have lost friends and boyfriends when I disclosed that I am diagnosed with schizophrenia. This does not happen at a Drop-In Center.

Another thing I love about Drop-In Centers are peer support groups. I participate in Schizophrenics Anonymous every week at Rebel's Drop-In Center. When I was first diagnosed I had been released from a psychiatric hospital in California. A case manager called the hospital to find out my diagnosis. When she said, "schizophrenia" I thought oh-no you are not talking about me. For the first five years after I was diagnosed there is no way I would admit that schizophrenia was my diagnosis. There was no way I was going to give in to a debilitating illness.

Participating in Schizophrenics Anonymous has helped me come to terms with being diagnosed. Through relating with my peers and understanding that we had shared experiences took away some of the stigma for me. Again, it is very powerful to realize your difficulties are not completely unique and you are not alone. Others have had paranoid feelings like yours. For example many people with schizophrenia have experienced receiving messages from the television and radio. In our groups we gently explain to each other that those feelings are not real. S.A. has greatly contributed to my acceptance of my illness.

Drop-In Centers and Peer Support groups are a great place to go to feel accepted and make friends. You can also learn an art form and be creative at a Drop-In Center. I have been an artist for about fifteen years. Creating art has been extremely therapeutic for me. On those tough days when I could do little else I could always sketch or string beads. Particularly during the long period of my life in which I was unemployed and receiving disability, my creative work was very important to me and gave me a sense of accomplishment. Rebel's Drop-In Center and 9Muses have great arts programs that teach the skills to express yourself creatively. All the supplies are provided for free by the center. All you have to do is show up.

I believe the Drop-In Centers we have here in Broward County are very valuable resource for the consumers of our community. It has been my privilege to play the role I do at Rebel's. I have seen lives change and people get back in their feet, working towards their dreams.

As staff at Rebel's we try to be caring and supportive of our members, this is as it should be. What I find remarkable, however, is what the members share with one another, the support they give one another, and shared hope for recovery.

Thank you for taking the time to read my experience.

Deanne O'Brien
Project Director
Rebel's Drop-In Center

20

Speech for Newly Proposed Medicaid Reforms

I am the proud Mother of four and a half year old triplets. One of my triplets, Alia, is totally disabled with cerebral palsy along with multiple other chronic illnesses, many of which can be life threatening without the proper care, treatments, doctors, specialists, medical supplies and medications.

Alia is unable to walk, talk, eat, or function whatsoever without total assistance. She is loved more by her family than words could ever express and is cared for in the best of hands. She is why I am here today; she cannot speak, so I speak for her.

Alia totally relies on Medicaid services for her nursing care on a daily basis, multiple medications that help her breathe and prevent her from being sick, medical supplies that allow her to be fed through a feeding tube and breathing devices, therapies that enable her to become mobile, endless doctor and specialists needed to manage her care, to the hospitalizations and ER visits that can come at any given moment and time.

The Governor's newly proposed Medicaid reforms would jeopardize these services for Alia in many ways. By placing Medicaid recipients in an HMO or other managed programs like it, (if any of these programs would even insure Alia based on her multiple diagnosis), it runs the risk of her services being subjected to being denied, reduced or cut out all together. The second issue suggests placing a dollar amount cap per recipient. Alia's medical needs change on a daily basis. She sees some sort of doctor or specialist every other week. When she is sick, her medications, doctor's visits, supplies, and all emergency care can double or quadruple. It would be impossible and unsafe to even attempt to place a dollar amount of predicted services on children like Alia. What happens when the cap is exceeded or what happens when the HMO or the managed care program decides to cut or deny a service? Where do we turn to then? Where would that leave Alia?

Without nursing services, Alia's health declines, without medications she cannot breathe, without medical supplies she cannot be fed and without her doctors, specialist or hospitals, she cannot get better. Her health cannot afford to have a reduction or cut in any of her services.

If budget cuts have to be made, they should not be made in a direction where it directly impacts the quality of care our sick children and elders get or do not get and so desperately needs just to survive.

Most people cannot possibly imagine how much is involved in the high maintenance care that Alia and other disabled people like her need or what their their little lives are like and what a struggle it is just to keep them alive and well. Alia does not choose to be sick, when to be sick, how often, or how much it will cost her to be sick and Alia, nor myself as her parent, should not have to worry if and what services will be covered for her precious care.

The Governor's proposals will cause more harm than good for our already most vulnerable and helpless people. If these reforms pass, it will further jeopardizing the lives of already fragile people that need the care the most. These proposals can literally mean the matter of life or death for Alia and other disabled persons like her. These proposals are not logical, sensible or safe for anyone who depends on Medicaid.

Please listen to what we are saying, on behalf of my daughter, Alia, and on behalf of the many others like her in this room today. We are the ones that will be directly affected by it.

Thank you.

Laura Northrup
On behalf of my precious daughter Alia Northrup
3531 Monumnet Drive
Deltona, FL 32738
407-328-0845

21

GEORGIADES.CELIA

From: Christine [Christine@vascularandsurgery.com]
Sent: Friday, February 25, 2005 4:17 PM
To: MEDICAID

Hi:
As a nurse in a surgeon's office we recently needed to set up wound care for a child in Sarasota county whose insurance was Staywell healthy kids. After going to the PCP for authorization I was told to get my own the next day....I did, because the wound care had been ordered to begin the previous evening and it was already midday on the second day & I wanted to be sure she had wound care done that day..it took over 2.5 hours on the phone (I was transferred repeatedly to the wrong dept's) and finally it was set up for that evening. (Two dressing changes had not been done!!... the evening of the appt day and the following AM) This took me away from additional obligations that I need to complete and I ended up having to stay late as a direct result of wound care arrangements. So my MD was informed of the "courteous" treatment I recieved while attempting to set this up and he has now decided to no longer accept any MEDICAID because of the high denial and low compensation rate.And he had to pay me OT. Do not make it so difficult and time consuming for office's and providers to get authorizations and pay when services have been rendered. Provide access to a web site or an ability to get a live person that speaks clear English and is knowledgeable to provide same day service. Thanks and sorry

(22)

ARTHUR G. DEMPSEY

7948 Riverdale Dr.
New Port Richey, Florida
34653
(727) 376-2452
Artman44@tampabay.rr.com

2/25/2005

Attn. Senate Select Committee on Medicaid Reform

Dear Senator,

I am writing to you on behalf of the Medicaid reform legislation that your committee is about to embark upon.

My Sister and I, both disabled, (I'm on a ventilator), by the cumulative effects of Muscular Dystrophy, have struggled to live in our Pasco County home, but under the very threat of being placed in a Nursing Home! You see, we were advised that the most practical recourse available to us, after the passing of our Mother and sole caregiver in 2001, was a Nursing home!

We are two, mentally alert, functioning adults, I am 61 and my Sister is 53, that are quite capable of managing our own existence! Despite our disability, we have done just that...took care of ourselves with the funds provided to me, through the C.D.C. Plus program; and, the aides provided to my sister, through a conventional program! My sister is presently on the waiting list for enrollment into the C.D.C. Plus program at this very time.

Now, I have been in the conventional Medicaid system since1988, (aides being furnished through a health care agency), after recovering from respiratory collapse that resulted in a 44 day hospital stay. In October of 2001 I had the exceptional opportunity to take part in an innovative program called, Consumer Directed Care!

Basically, this program allots a specific amount of funds to a consumer with which the consumer pays for aides, services and supplies directly, thereby eliminating the home health agency!

This method is so superior to the conventional method, inasmuch; as I can utilize the funds in more economical manner for my needs, by eliminating the middle man, (Health Care Agency), thereby obtaining more services for the dollar! I hire aides that I feel comfortable with and schedule them when their service will be more beneficial to MY wellbeing! My gratitude goes out to all those that were responsible for creating this program, such as Senator Mike Fasano and,

Governor Jeb Bush's foresight to sign this program into law!

Another major action you can endorse is to allow, those of us that require medical services, that are privileged to the nursing profession, be provided by a anyone employed by us! [Providing there is a signed release by the individual receiving the services.]

Example: Occasionally I require a suctioning procedure to be performed on me, a procedure that can only be provided by a nurse, and we all know how costly that can be! I train my friends to perform the same procedure…free, or for a lot less than a nurse! Not only that, but a better experience, repetition of a procedure with the same individual, or group, breeds familiarity!

The best way to stretch the Medicaid dollar is to cut costs! Allow the recipient freedom of choice by means of some kind of limited waiver policy!

Allow us to, at least, keep pace with inflation. In that way we can retain our competent help.

I would, most strongly, urge you to consider making the innovative Consumer Directed Care Plus program a viable option to nursing home internment!

I wish to thank you for your patience and allowing me to express my thoughts. Should you require further information from me, I would only be too happy to comply. I also have a website, that you may find of interest.

http://www.saveartman.com

Sincerely yours,

Arthur G. Dempsey

23

South County Mental Health Center

It has come to our attention that the Legislature and Florida Governor Jeb Bush are considering cutting back on Medicaid coverage for the mentally ill.

We represent the Client Government here at South County Mental Health Center (located in Delray Beach, Florida) which is comprised of hundreds of registered voters. It is our desire to move toward wellness, keep taxpayers from paying for costly ER visits, crisis stabilization, Baker Act commitments, law enforcement, corrections, and court system involvement. In order to do this *the Legislature must make the right decision and maintain the exemption for Medicaid patients requiring psychotropic medication (which the Legislature wisely enacted in 2000).*

We are compelled to remind you that the money saved by reduced charges for psychotropic meds will be overshadowed by increased hospitalizations and justice system involvement by those people not properly stabilized by medication.

Lastly, we wish to remind you that modern pharmaceuticals have allowed us a level of dignity and freedom that we could have never hoped for 20 years ago. Please do not take this away from us.

Looking forward to hearing your response. Senior Day Program Client Government @
South County Mental Health Center
16158 South Military Trail
Delray Beach, FL
33484

Sincerely,

Carol Humphrey, Client Government President

South County Mental Health Center

As staff members here at South County Mental Health Center we are concerned about proposed changes to Medicaid.

Serious mental illness can only be treated successfully by using a full spectrum of antipsychotics and antidepressants. A medicine that works for one patient may not work for another with the same symptoms. Additionally, the less expensive old time medications often produce negative side affects and do not improve the patients cognitive abilities the way newer drugs do.

Surely mentally ill patients that are denied access to appropriate medications may decompensate and become an unnecessary taxpayer expense through increased hospitalizations, crisis stabilization, Baker Act commitments, law enforcement, corrections, and court system involvement.

Please search for ways of developing a workable Florida budget (i.e. consider working with drug companies to make medications more affordable) that will not be at the expense of our most vulnerable citizens.

Looking forward to hearing your response @

South County Mental Health Center

c/o Howard Hazard

16158 South Military Trail

Delray Beach, FL

33484

Sincerely,

South County Day Treatment Staff

24

South County Mental Health Center

It has come to our attention that the Legislature and Florida Governor Jeb Bush are considering cutting back on Medicaid coverage for the mentally ill.

We represent the Client Government here at South County Mental Health Center (located in Delray Beach, Florida) which is comprised of hundreds of registered voters. It is our desire to move toward wellness, keep taxpayers from paying for costly ER visits, crisis stabilization, Baker Act commitments, law enforcement, corrections, and court system involvement. In order to do this *the Legislature must make the right decision and maintain the exemption for Medicaid patients requiring psychotropic medication (which the Legislature wisely enacted in 2000).*

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Lastly, we wish to remind you that modern pharmaceuticals have allowed us a level of dignity and freedom that we could have never hoped for 20 years ago. Please do not take this away from us.

Looking forward to hearing your response. ODC Client Government @
South County Mental Health Center
16158 South Military Trail
Delray Beach, FL
33484

Sincerely,

Richard Kahn, Client Government President

GARNER.MICHAEL

25

From: Barbara Benarroche [Benarrocheb@scmhcinc.org]
Sent: Thursday, February 10, 2005 1:52 PM
To: GARNER.MICHAEL
Subject: Medicaid

Dear Mr. Garner,

Limiting access to the newer anti-psychotics will have a detrimental effect on all psychiatric patient's but most dramatically to younger male patients. If you have ever seem the movement disorders that disfigure and stigmatize patients you would understand the need for the newer meds with less serious side effects.

Please do not allow the limiting of access to these drugs.

Thank you,

Barbara Kania Benarroche, ARNP,BC

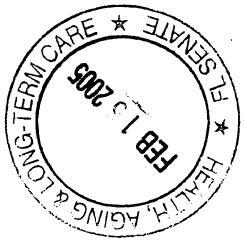
Florida Association of Homes for the Aging

An Organization of Retirement Housing and Health Care Communities

Scott Boord
Chair

1812 Riggins Road • Tallahassee, Florida 32308
(850) 671-3700 • Fax: (850) 671-3790
Website: *www.faha.org* • E-mail: *info@faha.org*

Janegale Boyd
President/CEO



26

February 11, 2005

The Honorable Burt Saunders
Chair, Senate Health and Human Services Appropriations
201 The Capitol
Tallahassee, FL 32399-1100

Dear Senator Saunders:

I was following with great interest the debate and questions related to Mr. Arnold's Proposed Medicaid Budget presentation in front of your committee on Thursday, February 10, 2005. The comments and questions offered by members of the committee were very encouraging, as it seems that there is now a general recognition that Florida cannot continually balance the budget on the backs of institutional providers.

Under the Governor's proposal, $199 million would be cut from the nursing home continuation budget. This level of reduction is just simply not sustainable by the nursing home community, and those homes that could cope with this kind of cut would have to compensate for the extra losses by increasing the daily charges to their private pay residents.

For your reference, I have attached the executive summary of the legislatively-mandated AHCA report regarding the adequacy of Medicaid nursing home payment rates. Please note, that in other parts of the report (page 14), the Agency notes that as of July 1, 2004, over 95 percent of the nursing homes receive a Medicaid rate that is below their cost of care. The report also observes that even the 90-100 percent Medicaid facilities are losing an average of almost $10 per day on each of their Medicaid residents. In a 120-bed facility this translates to more than $350,000 per year. These facilities have no options to cost shift, so their only alternative is to cut staff, services, and amenities. The quality gains made since SB1202 will soon be reversed. If we are to retain current staffing levels or, indeed if we are to increase them in the future, then reasonable Medicaid payment levels must be attained for the nursing home program in all of its components, not just direct care.

On behalf of FAHA's 100+ mission-driven nursing home members, I ask that you consider responsible funding for the nursing home program. We, on the other hand, commit to you that FAHA member homes and staff will work with your committee members and committee staff in your quest to reform the Medicaid program. Also attached for your consideration is our issue brief regarding the *Senior Health Choices* proposal developed by AHCA. Please note that we do support the call for a change and do offer several alternatives.

Thank you for your consideration.

Sincerely,

Erwin P. Bodo, Ph.D.
Chief Operating Officer

Attachments (2)
cc: Senate HHS Appropriations Committee Members
Ms. Elaine Peters, Staff Director
Senate Health Care Committee Members
John Wilson, Staff Director

CENTRAL FLORIDA BRANCH
Mary Ellen K. Early • 2303 Pin Oak Drive • Deland, FL 32720-8600 • (386) 738-0503 • Fax: (386) 738-1428
Central Florida Branch • 2303 Pin Oak Dr. • Deland, FL 32720 • (386) 738-0503 • Fax: (386) 738-1428 • *Mary Ellen Early*

Florida Medicaid

Nursing Home Cost and Payment Rates

EXECUTIVE SUMMARY

Background

Pursuant to HB 1837, Section 20, passed by the 2004 Florida Legislature, the Agency for Health Care Administration, in conjunction with the Florida Association of Homes for the Aging and the Florida Health Care Association, is required to evaluate the reimbursement methodology for Medicaid nursing home services to determine the adequacy of the current payment rates in meeting the costs of providing care to Florida's Medicaid residents. The report must make recommendations for changes in the current payment methodology or for development of a new payment methodology necessary to ensure a stable financial environment in which reimbursement is adequate to meet the costs of providing nursing home care for Florida's Medicaid residents served by a majority of nursing home providers. The Agency shall report its findings to the Speaker of the House of Representatives, the President of the Senate, and the Governor by December 1, 2004.

Analysis

The majority of the 643 Medicaid nursing homes in Florida are not being reimbursed 100% of their costs. This is particularly true for the Operating and Indirect Patient Care components of the per diem rate.

Before the rate reduction effective July 2004, the following received 100% of costs within the identified components of the per diem rates: 17.57% or 113 providers for the Operating component; 52.9% or 340 providers for the Indirect Patient Care component, after incentives; and 82.9% or 533 providers for the Direct Patient Care component, after incentives. After the rate reduction, there were no providers receiving their cost in the Operating component, 0.31% or 2 providers were receiving their cost in the Indirect Patient Care component after incentives, and the same 82.9% or 533 providers receiving cost in the Direct Patient Care component after incentives.

A comparison of providers' actual costs for January 1, 2003 through December 31, 2003 to the Medicaid actual reimbursement for the same period concluded that irrespective of their Medicaid utilization and component, the majority of providers did not have their actual Medicaid period costs covered by their actual Medicaid revenues.

A historical analysis of provider reimbursement rates versus cost, concluded that over the course of the past eleven years, the gap between provider costs and their provider target limitations has been slowly widening. Particularly, in the last five years, the Operating component has had the largest variance between cost and provider target limitations. See page seven for discussion of provider target limitations.

The reason that the Operating and Indirect Patient Care components are not receiving a majority of their costs is primarily due to the provider target limitation system. The target limitations within the Operating component have not been re-based since January 1993. A target re-basing simply resets the provider target limitations based on each provider's most recent costs multiplied by the inflation target factor. Without periodic re-basing to the target limitations, the difference between the growth rate of the costs versus the growth rate of the target inflation will continually increase, thereby creating a situation where eventually many, if not all, providers will be limited by target limitations. For these components, if the

provider target limitations were higher, providers would receive reimbursement for a higher percentage of their costs.

While the provider target limitation system has resulted in providers not receiving a higher percentage of their costs, it should be noted that the target limitation system is quite stable and assumes a very steady rate of growth. Factors outside of the target rate of inflation methodology influence costs resulting in a higher rate of growth than the target system recognizes.

Recommendations

The purpose of this report is to recommend options that would ensure adequate reimbursement to meet the costs of providing nursing home care services for Medicaid residents served by a majority of nursing home providers. For purposes of this report, "majority of nursing home providers" has been defined as 51% of all nursing homes participating in the Medicaid program. "Costs" have been defined as each provider's actual, inflated Operating, Direct Patient Care, Indirect Patient Care, and Property costs as reported in their most recently filed cost report. In order to ensure reimbursement that is adequate to meet the costs of a majority of nursing home providers, the following options are considered:

1. Using the current reimbursement methodology, and assuming the restoration of the $66 million rate reduction that went into effect beginning July 1, 2004, minor changes could be applied to the current methodology to reimburse 51% of all providers 100% of total costs. The first step would be to eliminate all target limitations for the Operating and Indirect Patient Care components, which would cost an estimated $77 million and $33 million, respectively. Additionally, revise all providers' Property component rates by making changes to both the Fair Rental Value System and the Cost methodology until 51% of all providers are reimbursed 100% of total facility cost, an additional cost of approximately $46 million. The annualized total cost during the first year of implementation is approximately $156 million, assuming the $66 million rate reduction is restored separately, or approximately $222 million in total.

2. Another option would include more significant changes to the current methodology, but would continue to employ its basic elements. These changes may include:
    a. Revising what is considered Medicaid allowable costs.
    b. Fixing one or more of the reimbursement components at a fixed level of reimbursement.
    c. Applying a factor to the total rate until a majority of providers are reimbursed their full costs.

Item (a) may alter the current measurements of cost and payments for services, therefore the exact funding required to implement this change cannot be determined, but is not expected to exceed the $156 million described in Option 1, assuming the $66 million rate reduction is restored separately. Item (c) would cost approximately $100 million in the first year of implementation, and also assumes the $66 million rate reduction is restored separately. A methodology for continuing item (c) after the initial year of implementation would have to be developed as it is inconsistent with the current system of reimbursement.

3. Implement a new Acuity-Based Reimbursement System. The cost/savings to the State is unknown at this time as further analysis is required to quantify the details of such a system. If it is assumed that a majority of providers should be reimbursed 100% of their costs at any given time, then the overall cost of this system is anticipated to be in line with the costs described in Option 1.

Florida Association of Homes for the Aging
An Organization of Retirement Housing and Health Care Communities
1812 Riggins Road, Tallahassee, FL 32308
Phone: 850/671-3700 ◆ FAX: 850/671-3699 ◆ Web site: www.faha.org

Comments on *Senior Health Choices*

The Integrated Managed Long-Term Care Plan for Florida Seniors

The Florida Association of Homes for the Aging (FAHA) supports the call for a fundamental change in the way long-term care services are delivered as proposed by the Agency for Health Care Administration (AHCA) in its December 31, 2004 publication *Senior Health Choices*.

FAHA believes that the overall growth in the Medicaid budget, and in particular, the long-term care component of that budget, while not unreasonable when compared to increases in private insurance rates, is not sustainable into the distant future without the infusion of new revenues. A more efficient service delivery system, where care management plays an integral role, such as proposed by *Senior Health Choices*, may offer the best potential infrastructure. The success of any new system will, however, depend to a very large extent on the reasonableness of its funding. It may well be the case that substantial up front investments must be made to ensure that true savings are realized in future years, instead of just reductions in payments, service quality, and access.

In the past, and indeed with the current recommendations contained in the proposed Fiscal Year 2005-2006 budget, our state has tried to balance the long-term care component of the budget on the backs of the service providers. This can no longer continue, especially if we would like to maintain the gains in quality we achieved in the last few years. Staffing is at an all-time high, but sadly, so is the percentage of nursing home providers who receive Medicaid payments inadequate to pay for the cost of care. (Please see the legislatively-mandated AHCA study on the adequacy of the nursing home payment system. The executive summary is attached.)

Florida is already one of the lowest cost states when it comes to funding long-term care. Beds per thousand elderly and per capita elderly expenditures both rank very near the bottom. However, where Florida does not excel is in the proportion of long-term care funds spent on community based services. The problem is not too many dollars spent on nursing home care, but rather not enough spent on potential alternatives. Additionally, the nursing home care is highly regulated and Florida has one of the nation's highest direct care staffing requirements.

Our rapidly-growing elderly population contributes significantly to our state's healthy economy, and our seniors must be thought of as a treasured state resource. As such, we must ensure that our efforts to exercise budgetary constraint are balanced and do not financially weaken the community of long-term care providers to such an extent that access to high-quality long-term care be limited or largely unavailable to the state's frail elderly when their need for such services arises.

The state's quest to limit projected rates of increase in Medicaid long-term care program costs cannot be achieved without significant negative impact on consumer choice, quality of services delivered, and service provider financial stability. If an artificial budgetary limit is imposed, at least one of these three factors will be adversely affected. Therefore, FAHA's recommendations for reengineering the state's long-term care system are focused on balancing increased efficiency with consumer choice, quality of service, and payment adequacy.

- **Efficiency** -- The efficiency of the long-term care service delivery system can be increased by managing the total care of seniors. We must do a better job ensuring that the right services are delivered to the right individual at the right time. While inappropriate nursing home placement may be costly, inappropriate community placement could be potentially deadly. The imposition of a care management component is necessary if we want to implement the most efficient service delivery system. This is the basic framework of *Senior Health Choices*. But, the use of health maintenance organizations or managed care organizations in general, is only one of the possible solutions. The state could implement the care management component by contracting for such a service, such as it does with the disease management projects. Florida could also implement its own care management system as an extension of CARES (Florida's preadmission screening program), or with the yet to be formed Aging Resource Centers. Indeed arguments can be made that the care manager should be independent from the care provider to eliminate conflicts of interest. Further, the use of a care management organization usually introduces a 15-20 percent overhead, which if not directly funded would have to come out of the dollars we now spend on services. The decision to implement a care management component can be made independently from the decision regarding privatization. If managed care organizations are the final choice, then care must also be exercised to ensure that a fee-for-service backup exists in case a catastrophic failure of the contractors occurs. We must

bear in mind that at least in the case of assisted living facilities and nursing homes, the care provider also serves as the home for the individual. FAHA believes that care management can be implemented in Florida without complete privatization.

- **Consumer Choice** -- Care management should be coupled with extensive consumer choices. Under the current proposal of *Senior Health Choices*, the only choice enrollees have is between two managed care organizations. Consumer choice based on religion, ethnicity, facility proximity to family, or the quality of providers must be addressed. Additionally, we should provide for consumers to use out-of-network providers by implementing a provision somewhat similar to the "cash and counseling" pilot projects. Conceptually, an enrollee could be given the equivalent of a voucher for approved services, and such a voucher could be supplemented by additional payments from the enrollee or his or her family if they chose an out-of-network provider. The choice of out-of-network providers will foster the creation of the best possible quality in managed care organization networks and will give consumers the freedom to supplement their benefit package by paying for higher quality or more desirable services. This issue is particularly important to retirement communities, where a resident should have the option of returning to his/her home community's nursing home after a hospital stay, even if that nursing home is not in the network.

- **Quality of Service** -- The state should take this opportunity to reward those nursing home providers that have a proven record of high quality of service by offering incentives during contracting and/or rate negotiations. *Senior Health Choices*, as directed by the enabling legislation, calls for required contracts with Gold Seal nursing homes. But we must go further and ensure that quality plays at least as important a job as price in the formation of provider networks. Also, by denying contracts to those few facilities that have not demonstrated a good track record, we would elevate the overall quality of care to all Medicaid nursing home residents and improve our chances for the development of affordable liability insurance products. The existing nursing home guide could serve as the basis for evaluating the quality of nursing home providers. Nursing homes that score three or more stars on that report should be given preferences when service networks are developed or client caseload is reallocated.

  Mission-driven and non-profit providers have been committed to expanding their mission to provide a high-quality full continuum of care. Through the aging network, continuing care retirement communities, and a number of other non-profit organizations, frail elders currently have access to a variety of long-term care services. While these organizations do strive to stay in the black through their community support, charitable contributions, and volunteer networks, they add significant value to each Medicaid dollar spent on their service. We need to encourage the further development and expansion of non-profit resources and service providers and we need to ensure that these organizations remain financially strong.

- **Payment Adequacy** -- With over 95 percent of the state's nursing homes receiving Medicaid payment rates below their cost of care, any change to the system must include some normalization of the payment rates. An AHCA study on Medicaid nursing home payment rates, which is soon to be published, confirms what FAHA has been advocating for years and supported by the Tax Watch study of 2004 -- the financial viability of nursing home providers is perilously close to the failure point. The average loss of over $17 per Medicaid resident per day (over $400,000 per year for the average nursing home) is projected to nearly double if the Governor's budget recommendations are implemented. Facilities with an adequate private pay census will have to increase their private pay rates to supplement Medicaid. We should strive to repeal this unfair, hidden "tax". In facilities with a low private pay census, the results are more problematic as cost shifting is not feasible, and therefore reduction in service is the only viable answer. We must ensure that in a new long-term care system, care management contractors and service providers both receive actuarially adequate payment rates.

- **Additional Suggestions** -- The state should increase its efforts to prevent artificial impoverishment; that is, the shielding of assets in order to become Medicaid eligible. HB 543 by Representative Brown addresses this issue. We should also strive to increase the use of private long-term care insurance, such as suggested in HB 371 by Representative Legg. The nursing home certificate of need moratorium will sunset in 2006. The state should reinstate the moratorium with some minor exceptions in areas where occupancy is unacceptably too high, to encourage the development and use of home and community based settings to the greatest extent. Finally, the state should consider a pilot project where the Medicaid and Medicare funding is merged, like in the PACE project.

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2/10/05

GARNER.MICHAEL

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From: Barbara Benarroche [Benarrocheb@scmhcinc.org]
Sent: Thursday, February 10, 2005 1:52 PM
To: GARNER.MICHAEL
Subject: Medicaid

Dear Mr. Garner,

Limiting access to the newer anti-psychotics will have a detrimental effect on all psychiatric patient's but most dramatically to younger male patients. If you have ever seem the movement disorders that disfigure and stigmatize patients you would understand the need for the newer meds with less serious side effects.

Please do not allow the limiting of access to these drugs.

Thank you,

Barbara Kania Benarroche, ARNP,BC